NOTE: PURSUANT TO S 130 OF THE INTELLECTUAL DISABILITY (COMPULSORY CARE AND REHABILITATION) ACT 2003, ANY REPORT OF THIS PROCEEDING MUST COMPLY WITH SS 11B, 11C AND 11D OF THE FAMILY COURT ACT 1980.

IN THE HIGH COURT OF NEW ZEALAND
WELLINGTON REGISTRY

I TE KŌTI MATUA O AOTEAROA
TE WHANGANUI-Ā-TARA ROHE

CIV-2017-485-25
[2018] NZHC 1209

UNDER	The Statutes of Westminster the First 1275, The Bill of Rights Act 1688, The Judicature Amendment Act 1982, The New Zealand Bill of Rights Act 1990, The Criminal Procedure (Mentally Impaired Persons) Act 2003, The Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 and the Common Law
IN THE MATTER	Of an application for Judicial Review, Declarations of Inconsistency, and Public Law Compensation
BETWEEN	J, COMPULSORY CARE RECIPIENT, BY HIS WELFARE GUARDIAN, T Applicant
AND	THE ATTORNEY-GENERAL First Defendant
	THE DISTRICT COURT AT MANUKAU Second Defendant
	THE FAMILY COURT AT MANUKAU Third Defendant
	THE CARE CO-ORDINATOR Fourth Defendant
	THE CARE MANAGER Fifth Defendant

Hearing: 3 – 11 July 2017

Appearances: T J Ellis and G K Edgeler for Applicant
M J McKillop and O J G Upperton for First Defendant
M G Coleman and I S Auld for Fourth Defendant

Judgment: 25 May 2018

JUDGMENT OF CULL J

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INTRODUCTION

The four proceedings

[1] J has an intellectual disability and is a care recipient who has been in supervised and/or secure care since 8 February 2006, after being found unfit to stand trial on two criminal charges. J is 34 years old and through his welfare guardian, his mother, challenges the validity of his compulsory care orders by way of four separate proceedings.

[2] The Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR Act) provides for appropriate compulsory care of individuals who have an intellectual disability and who are convicted of an offence.[1] The Criminal Procedure (Mentally Impaired Persons) Act 2003 (CPMIP Act) provides for orders that a defendant be cared for as a care recipient under the IDCCR Act, when a defendant is found unfit to stand trial.[2]

[3] This judgment addresses the four separate proceedings before this Court, which were heard together.[3] They are:

(a) an appeal under ss 16 and 17 of the CPMIP Act, against the findings of J's involvement in the alleged criminal offending, unfitness and disability and the orders that J be held as a care recipient under the IDCCR Act. This will be referred to as the "CPMIP appeal", including the application for leave to bring the appeal over 12 years out of time;

(b) an appeal from the Family Court order on 27 February 2017, which extended J's care order by a period of 18 months and varied it to secure compulsory care order;

(c) a s 102 IDCCR Act inquiry by the High Court into the legality of detaining J as a care recipient; and

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1 Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 3.
2 Criminal Procedure (Mentally Impaired Persons) Act 2003, s 24.
3 As directed by Collins J in *J v Attorney-General* [2017] NZHC 701 at [46]–[48].

(d) an application for judicial review challenging the arbitrary detention of J, the discriminatory nature of the IDCCR Act and breaches of the New Zealand Bill of Rights Act 1990 (NZBORA).

Structure of the judgment

[4] In this judgment, I propose to deal with general matters common to all four proceedings, followed by an analysis of each of the proceedings, with the chronology and the party's respective positions relevant to each. The structure I adopt is as follows:

(a) Background facts and relevant chronology;

(b) The relevant disability legislation of New Zealand;

(c) Part 1 – CPMIP appeal;

(d) Part 2 – the Family Court appeal;

(e) Part 3 – s 102 IDCCR Act inquiry application;

(f) Part 4 – the judicial review proceedings; and

(g) Summary of conclusion.

BACKGROUND FACTS AND RELEVANT CHRONOLOGY

[5] The background facts were canvassed by Collins J in a judgment addressing five pre-trial questions of law concerning the validity of the orders made in relation to J, under the CPMIP Act and the IDCCR Act.[4] The pre-trial questions of law arose from an application filed by Dr Ellis on behalf of J, for a habeas corpus order. The application was dismissed, on the basis that the multiple arguments raised in the application were not amenable to a habeas corpus hearing and that an application for judicial review was more appropriate.[5]

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4 *J*, above n 3, at [5]–[8].
5 At [40]; and *J v Care Manager* [2017] NZHC 15.

[6] In delivering his judgment, Collins J succinctly canvassed the background facts, which I set out below:[6]

> [5] J, who is now 33 years old, was diagnosed with autistic spectrum disorder at an early age. In addition, J has been assessed as having a low IQ. An assessment of J's IQ, using a Wechsler Adult Intelligence Test (WAI-III) was conducted in 2005 when J was 21 years old and revealed he had a Full-Scale Intelligence Quota of between 58 and 68, functioning below 99.5 [per cent] of similar aged peers. A report from Dr Jensen, a registered clinical psychologist, dated 13 November 2016 states J's IQ is unlikely to have changed since he was assessed in 2005. Dr Webb, a registered psychologist, also recently assessed J's IQ using a Wechsler Adult Intelligence Test (WAI-IV) and considered J to have intellectual disabilities.
>
> [6] Reports from health professionals who have assessed J record that he has violent fantasies, engages in impulsive violent behaviour and does not have an understanding that his violent behaviour could cause harm. The earliest recorded example of J's violent behaviour was in 2000 when he attempted to injure another student by cutting her neck. J's recorded violent fantasies include a belief he was James Bond and that he was on "missions". These "missions" included J breaking into a school building in 2004 to cut a teacher's head off. Health professionals have described their concerns about the risk J poses through pictures he has drawn and descriptions given of the removal of people's feet or cutting their necks open. Other examples of the risk it is believed J poses and his lack of appreciation of consequences can be found in reports, which describe how he tried to grab the driver of a vehicle in which he was being transported that was travelling at speed because he wanted to experience being in an accident.
>
> [7] In 2004, J was charged with two minor offences, namely being unlawfully in an enclosed yard and wilful damage. He was, at the same time, charged with the more serious offence of being in possession of an offensive weapon. That charge however appears to have been discontinued at an early stage.
>
> [8] On 8 February 2006, Judge R L Kerr made an order in the Manukau District Court that J was not fit to stand trial. This order was made under the CPMIP Act. Concurrently, Judge Kerr ordered J be cared for as a care recipient under the IDCCR Act. The latter order meant that he was deemed to be subject to a compulsory care order under the IDCCR Act.

[7] A detailed chronology of the orders which have been made in respect of J from 8 February 2006 to 28 February 2017, being the period of time over which J has been held as a care recipient receiving supervised care under the IDCCR Act, is contained in appendix 1 to this judgment.

[8] The relevant parts of the chronology are explored in more detail, where relevant, in respect of each of the four proceedings.

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6 Footnotes omitted.

THE RELEVANT DISABILITY LEGISLATION IN NEW ZEALAND

[9] Before embarking on an analysis of each of the four proceedings, it is relevant to address the legislation, which governs the matters raised in all four proceedings. The relevant acts are the CPMIP Act and the IDCCR Act. Although the CPMIP Act was enacted in 2003, both the CPMIP and IDCCR Acts came into force on 1 September 2004, approximately three months after the date of J's offending on 8 June 2004.[7]

[10] At the time of J's appearance before the District Court in June 2004, the provisions of the Criminal Justice Act 1985 (CJA) governed the procedure for persons who were "under disability". After 1 September 2004, both the CPMIP and IDCCR Acts applied and governed the procedural steps, including the ultimate disposition in J's case, to a secure facility under the IDCCR Act.

Criminal Justice Act 1985

[11] Up to 1 September 2004, Part 7 of the CJA conferred powers on the courts in respect of persons who were charged with imprisonable criminal offending but were "under disability".[8]

[12] The meaning of "under disability", was defined under s 108 of the CJA, as being a person who was "mentally disordered" and was unable:

(a) to plead; or

(b) to understand the nature of purpose of the proceedings; or

(c) to communicate adequately with counsel for the purposes of conducting a defence.

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7 Criminal Procedure (Mentally Impaired Persons) Act Commencement Order 2004, cl 2; and Intellectual Disability (Compulsory Care and Rehabilitation) Act Commencement Order 2004, cl 2(2).

8 Part 7 of the Criminal Justice Act 1985 was repealed by the Criminal Procedure (Mentally Impaired Persons) Act 2003, s 48.

[13] Section 111 of the CJA governed the decisions as to whether a person was under disability. A judge was empowered to make such an order, on the evidence of two specialists, who were required to provide reports to the court.

[14] The power of the court to require a psychiatric report was contained under s 121 of the CJA, if a psychiatric report would assist the court in determining if a defendant was under disability.[9] It was under this provision, that the District Court in Manukau ordered a formal psychiatric assessment for J, when J appeared in Court on 9 June 2004 on three criminal charges.

CPMIP Act

[15] The CPMIP Act provides a means of triaging defendants charged with criminal offences. Those who are fit to stand trial are subject to the criminal justice system. Those who are unfit to stand trial are subject to care orders under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHCAT Act) or the IDCCR Act respectively. Thus, the CPMIP Act works in tandem with the IDCCR Act and the MHCAT Act, where applicable. The CPMIP Act replaced and restated the law as contained in the CJA, making a number of changes to that law.[10] Section 3 of the CPMIP Act states its purpose as follows:

> **3 Purpose**
>
> The purpose of this Act is to restate the law formerly set out in Part 7 of the Criminal Justice Act 1985 and to make a number of changes to that law, including changes to—
>
> (a) provide the courts with appropriate options for the detention, assessment, and care of defendants and offenders with an intellectual disability:
>
> (b) provide that a defendant may not be found unfit to stand trial for an offence unless the evidence against the defendant is sufficient to establish that the defendant caused the act or omission that forms the basis of the offence:
>
> (c) provide for a number of related matters.

---

9 Criminal Justice Act 1985, s 121(1)(a).

10 For a review of the legislative history of the mental health legislation as well as CPMIP Act and the IDCCR Act, refer to the review by Ellis J in *S v Attorney-General* [2017] NZHC 2629 at [43]–[99].

[16] The definition of "unfit to stand trial" in relation to an offender relies for its threshold on "mental impairment", as distinct from "mental disorder" defined in s 2(1) of the MHCAT Act. The definition of "unfit to stand trial" in the CPMIP Act, as defined in relation to a defendant:[11]

> (a) means a defendant who is unable, due to mental impairment, to conduct a defence or to instruct counsel to do so; and
>
> (b) includes a defendant who, due to mental impairment, is unable–
>
> (i) to plead:
>
> (ii) to adequately understand the nature or purpose or possible consequences of the proceedings:
>
> (iii) to communicate adequately with counsel for the purposes of conducting a defence.

[17] Although the term "mental impairment" is not defined, as Ellis J observed in *S v Attorney-General*,[12] "it is plainly (on both a literal and purposive interpretative approach) wide enough to encompass intellectual disability".[13]

[18] Before a defendant can be found unfit to stand trial, the court must be satisfied on the balance of probabilities that the defendant caused the act or omission that forms the basis of the offence as charged.[14] Once the court is satisfied of the defendant's involvement in the offence, the court must record its finding on the matter[15] and then receive the evidence of two health assessors as to whether the defendant is mentally impaired.[16]

[19] Again, the court must be satisfied on the balance of probabilities from the evidence of the two health assessors that the defendant is mentally impaired.[17] The court must record a finding to that effect, after giving each party an opportunity to be heard.[18] Once a defendant has been found unfit to stand trial (or acquitted on account of his or her insanity), the court can detain the defendant in a hospital as a special

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11 Criminal Procedure (Mentally Impaired Persons) Act 2003, s 4(1).
12 *S,* above n 10.
13 At [53].
14 Criminal Procedure (Mentally Impaired Persons) Act 2003, ss 3(b) and 9.
15 Section 13.
16 Section 14(1).
17 Section 14(3).
18 Section 14(2).

patient under the MHCAT Act or in a secure facility as a special care recipient under the IDCCR Act.[19] Alternatively, where such detention is not necessary, the court must deal with the defendant by:[20]

(a) ordering the defendant be treated as a patient under the MHCAT Act; or

(b) ordering the defendant be cared for as a care recipient under the IDCCR Act; or

(c) deciding not to make an order if the person is liable to serve a sentence of imprisonment; or

(d) ordering the immediate release of the defendant.

The IDCCR Act

[20] The purposes and principles of the IDCCR Act are set out in s 3 of the Act. Importantly, the legislative aim was to provide courts with appropriate compulsory care and rehabilitation options for offenders who have an intellectual disability and who previously had no other options (unless mentally disordered) than imprisonment for serious offending. The purposes in s 3 are:

> (a) to provide courts with appropriate compulsory care and rehabilitation options for persons who have an intellectual disability and who are charged with, or convicted of, an offence; and
>
> (b) to recognise and safeguard the special rights of individuals subject to this Act; and
>
> (c) to provide for the appropriate use of different levels of care for individuals who, while no longer subject to the criminal justice system, remain subject to this Act.

[21] The IDCCR Act also provides principles, which govern the exercise of powers under the Act and they are set out in s 11, as follows:

> **11 Principles governing exercise of powers under this Act**

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19 Section 24(2).
20 Section 25(1).

> Every court or person who exercises, or proposes to exercise, a power under this Act in respect of a care recipient must be guided by the principle that the care recipient should be treated so as to protect—
>
> (a) the health and safety of the care recipient and of others; and
>
> (b) the rights of the care recipient.

[22] There are three gateways to the IDCCR Act provisions:

(a) by referral from a court during criminal proceedings, through the CPMIP Act procedure;[21]

(b) by transfer of sentenced prisoners from prison;[22] and

(c) by transfer of those who were originally placed under orders under the MHCAT Act.[23]

[23] Of relevance to all of the four proceedings in this matter, J entered the IDCCR Act provisions by way of an order under s 25(1)(b) of the CPMIP Act, made in the District Court on 8 February 2006.

[24] Once an order is made under s 25(1)(b) of the CPMIP Act, by reason of s 26(2) CPMIP Act, that order is deemed to be an order for the purposes of the IDCCR Act, as illustrated by the orders affecting J.

[25] As will be explored further, the term "intellectual disability" is the threshold test, for the exercise of the provisions under the IDCCR Act. "Intellectual disability" is defined in s 7(1) as meaning a permanent impairment that:

> (a) results in significantly sub-average general intelligence; and
>
> (b) results in significant deficits in adaptive functioning, as measured by tests generally used by clinicians, in at least 2 of the skills listed in subsection (4); and
>
> (c) became apparent during the developmental period of the person.

---

21 Criminal Procedure (Mentally Impaired Persons) Act 2003, ss 24 and 25.
22 Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, ss 29–46.
23 For example, Mental Health (Compulsory Assessment and Treatment) Act 1992, s 47A.

[26] Importantly, ss 7(3) and (4) refine that further by:

> (3) For the purposes of subsection (1)(a), an assessment of a person's general intelligence is indicative of significantly sub-average general intelligence if it results in an intelligence quotient that is expressed—
>
> (a) as 70 or less; and
>
> (b) with a confidence level of not less than 95%.
>
> (4) The skills referred to in subsection (1)(b) are—
>
> (a) communication:
>
> (b) self-care:
>
> (c) home living:
>
> (d) social skills:
>
> (e) use of community services:
>
> (f) self-direction:
>
> (g) health and safety:
>
> (h) reading, writing, and arithmetic:
>
> (i) leisure and work.

[27] I turn then to consider each of the proceedings.

PART 1 - THE CPMIP APPEAL

[28] On 9 June 2004, J was charged with three offences, including two minor offences of being unlawfully in an enclosed yard[24] and intentional damage.[25] The third charge was the more serious offence of being in possession of an offensive weapon. That charge was withdrawn at an early stage.

[29] The summary of facts records that J went to a neighbouring property with a large axe, which he used to break two windows of a neighbour's garage and continued to break the front, rear and side windscreens of the neighbour's work van. J's mother arrived at the scene and restrained J from causing any further damage. J cut his hand on the broken glass and was required to be taken to hospital. When J was asked for

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[24] Summary Offences Act 1981, s 29(1)(b) with a maximum penalty of three months' imprisonment.
[25] Section 11(1)(a). The maximum penalty is also three months' imprisonment.

an explanation, he said he was "James Bond and licensed to kill." J was aged 20 years at the time. He had previously appeared before the Court.

The conviction and sentence decisions – 2004 to 2006

[30] As detailed below, findings under the CPMIP Act as to the defendant's involvement in the offence, under s 9, and unfitness to stand trial, under s 14, are treated as convictions for the purpose of any appeal right.[26] Dispositions and orders made under ss 24, 25 or 27 of the CPMIP Act are treated as a sentence for the purpose of any appeal.[27]

[31] The decisions, which are subject to this appeal, cover the date from which J first made an appearance on 9 June 2004 to the ultimate disposition hearing on 8 February 2006. From 9 June 2004 to 8 February 2006, assessments, remands, call-over appearances, a disability hearing and further appearances on J's behalf were made before a number of District Court Judges. The following is a chronology of key dates:

9 June 2004	J charged with wilful damage, possession of offensive weapon and unlawfully in an enclosed yard. J remanded on bail and psychiatric report ordered under s 121(2)(a) of the CJA.
8 July 2004	J assessed by psychiatrist Dr P Fernandez for preparation of s 121(2)(a) CJA report.
9 July 2004	J bailed to live at an address directed by RIDCA.[28]
12 July 2004	Psychological risk assessment report prepared by psychologist Dr M Sinclair.
14 July 2004	District Court orders second opinion under s 121(2)(6)(i) of the CJA.
31 August 2004	J assessed by Dr T Burgess, a MOSS[29] at the Regional Forensic Psychiatry Services, for preparation of a s 121(2)(a) CJA report.
15 September to 2 November 2004	Three further callover appearances on behalf of J.
17 September 2004	J, through his solicitor, notified of police decision to proceed with CPMIP Act procedure.

[26] Criminal Procedure (Mentally Impaired Persons) Act 2003, s 16(2).
[27] Section 29.
[28] Regional Intellectual Disability Care Agency.
[29] Medical Officer Special Scale.

7 February 2005	**Disability hearing under ss 9 and 14 CPMIP Act; findings of involvement and of disability (unfit to plead). J was bailed to reside at Solway Trust (Tuakau) under s 23(2)(a) CPMIP Act and disposition inquiries ordered.**
4 March 2005	Specialist assessment completed by T Breen, clinical psychologist.
7 March 2005 to 27 October 2005	Further reassessment report from T Breen received, adjournments with J's appearance excused and J's change of counsel occurs.
7 November 2005	Disposition hearing set down for 7 February 2006 and report from Mr Woodcock, registered psychologist, received.
8 February 2006	Disposition hearing under CPMIP Act. **Order made under s 25(1)(b) CPMIP Act that J be held in a secure facility as a care recipient, under the IDCCR Act.**

[32] In summary, J was remanded from 9 June 2004 to 8 February 2006, initially on bail, to attend the preparation and assessments for the s 121(2)(a) CJA reports. Following the disability hearing on 7 February 2005, in which findings of his involvement in the offending and his unfitness to stand trial were made, J was bailed to reside at the Solway Trust facility. A disposition hearing was then held on 8 February 2006, at which Judge R L Kerr ordered J be cared for as a care recipient under the IDCCR Act pursuant to s 25(1)(b) of the CPMIP Act.[30]

Issues on appeal

[33] On 27 April 2017, a notice of general appeal was filed on behalf of J, against the District Court findings in respect of the two criminal charges of wilful damage and being unlawfully in a yard. Consistent with the legislation, the appeal is a conviction and sentence appeal, with the ss 9 and 14 CPMIP Act findings equating to convictions and the s 25 CPMIP Act disposition being the equivalent of a sentence.

[34] In the original notice of appeal, the grounds advanced were that "remand on bail for 22 months under house arrest followed by detention in a secure facility for two

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[30] *New Zealand Police v [J]* DC Manukau CRN-409-203-4925-26, 8 February 2006 [*Disposition decision*]. While the Court record notes the disposition hearing occurred on 7 February 2006, the oral decision of Judge Kerr, made on 8 February 2006, records the hearing taking place the same day (8 February 2006). In this judgment, the disposition hearing will be deemed to have taken place on 8 February 2006. The Judge referred to both ss 24 and 25(1)(b) of the CPMIP Act when making the disposition order, as required under s 25(1), but the order was made under s 25(1)(b) as Collins J clarified.

years was both manifestly excessive and disproportionately severe. The appellant was wrongly found to be intellectually disabled." By the time of the hearing, the grounds of appeal had been amended and the following nine were advanced:

(a) Ground 1 – a prejudicial profile of J was created by health professionals that caused a serious miscarriage of justice.

(b) Ground 2 – no record or reasons were given for the s 9 CPMIP Act hearing or decision, which was unfair.

(c) Ground 3 – no hearing or reasons were given for the s 14 CPMIP Act finding.

(d) Ground 4 – J was wrongly found to have an intellectual disability.

(e) Ground 5 – other defences, such as temporary insanity, for J were not considered.

(f) Ground 6 – undue delay in conducting inquiries was contrary to s 23 CPMIP Act.

(g) Ground 7 – the health professional reports were inadmissible.

(h) Ground 8 – the disposition under s 25 CPMIP Act was unlawful.

(i) Ground 9 – the CPMIP Act process is discriminatory.[31]

Approach to appeal

[35] The relevant approaches to appeal that applied under the CPMIP Act at the time of the District Court findings are outlined below. Essentially, the question to be determined is whether there was sufficient evidence at the time of the conviction to make the relevant orders.

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[31] This ground is also common to the Family Court appeal and judicial review.

[36] The approach to an appeal, against a determination that a defendant is involved in an offence (ss 9–13) and unfit to stand trial (s 14), is governed by ss 16 and 17 of the CPMIP Act:[32]

> **16 Appeal by defendant against finding relating to fitness to stand trial**
>
> (1) A defendant about whom a finding under section 14(2)(b) has been made may appeal against one or both of the following findings:
>
> (a) that the evidence against the defendant is sufficient to establish that the defendant caused the act or omission that forms the basis of the offence with which the defendant is charged:
>
> (b) that the defendant is unfit to stand trial or, as the case may be, fit to stand trial.
>
> (2) For the purposes of an appeal under this section,—
>
> (a) the finding appealed against is to be regarded as a conviction; and
>
> (b) the provisions of the Crimes Act 1961 or the Summary Proceedings Act 1957 relating to appeals against conviction, so far as they are applicable and with any necessary modifications, apply to the appeal.
>
> **17 Matters for appellate court on appeal under section 16**
>
> (1) If, on an appeal under section 16, the court is satisfied that the evidence against the defendant is not sufficient to establish that the appellant caused the act or omission that forms the basis of the offence with which the appellant is charged, the court must quash the finding appealed against and direct that the appellant be discharged.
>
> (2) A discharge under subsection (1) does not amount to an acquittal.
>
> (3) In the case of an appeal against a finding relating to the appellant's fitness to stand trial, the court must (except where the appellant has been discharged under subsection (1)) consider the evidence of 2 health assessors, and confirm or quash the finding relating to the appellant's mental impairment.
>
> (4) If the court is satisfied that the appellant is mentally impaired, the court must—
>
> (a) give the appellant and the respondent an opportunity to be heard and to present evidence as to whether the appellant is unfit to stand trial; and

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[32] The versions of the provisions reproduced here are those which applied on 7 February 2005 when the District Court determined J was involved in the offence (s 9 CPMIP Act) and was unfit to stand trial (s 14 CPMIP Act).

(b) confirm or quash the finding relating to the appellant's fitness to stand trial.

(5) If the result of the appeal is that the appellant is fit to stand trial, the court must remit the case to the High Court or the District Court, as the case may require.

[37] The approach to an appeal against a disposition order under s 25 is governed by s 29 of the CPMIP Act:[33]

> **29 Appeals against orders under section 24 or section 25 or section 27**
>
> (1) If the court makes an order or a decision under section 24 or section 25 or section 27, the defendant and the prosecution have the same right of appeal against the order or decision as the defendant or, as the case requires, the prosecution would have if the order or decision were a sentence.
>
> (2) The provisions of the Crimes Act 1961 or the Summary Proceedings Act 1957 relating to appeals, so far as they are applicable and with any necessary modifications, apply to the appeal.
>
> (3) On such an appeal, the court may—
>
> (a) dismiss the appeal:
>
> (b) vary the order appealed against:
>
> (c) cancel the order or decision appealed against and substitute another order or decision under section 24 or section 25 or section 27.

[38] As ss 16 and 29 of the CPMIP Act specify, this appeal is an appeal against conviction (ss 9 and 14 findings) and sentence (s 25(1)(b) order). As discussed earlier,[34] the Summary Proceedings Act appeal process also applies. Section 115(2) and (4) of the Summary Proceedings Act provides that both conviction and sentence appeals are general appeals to the High Court.[35]

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33 The relevant version of the provision reproduced here is that which applied on 8 February 2006 when the District Court ordered J be held as a care recipient under the IDCCR Act (order per s 25(1)(b) of the CPMIP Act).

34 At [43] of this judgment.

35 It is also worth noting that this is in contrast to a sentence appeal brought at the same time under s 385 of the Crimes Act 1961 (prior to the introduction of the Criminal Procedure Act 2011), which was not a general appeal but an appeal against a discretion. See *R v Shipton* [2007] 2 NZLR 218 (CA) at [138]–[140].

Parties' positions

[39] Counsel for J, Dr Ellis, submits that as the criminal process was the starting point of J's formal disability findings, if J was improperly "convicted" or "sentenced" under the CPMIP Act, the need for the substantive argument in the remaining three proceedings diminishes. In other words, using Dr Ellis' terminology, a successful CPMIP appeal is a "silver bullet" for J, as it invalidates any subsequent order made by the District Court in respect of J.

[40] The Crown, on behalf of the Police, submit that leave to appeal out of time ought to be declined, because apart from delay in bringing this appeal, it is not necessary in the interests of justice to grant J leave to appeal, where he has the ability to challenge his continuing detention through other means. If leave to appeal is granted, the Crown submits the appeal ought to be dismissed as the Court's findings as to J's involvement in the offending and unfitness to stand trial were correct. The Court's disposition of J as a care recipient was lawful and non-discriminatory.

Preliminary matters

[41] Before addressing each of the grounds of appeal as advanced, there are two preliminary issues to be considered, the first of which involves J's application for leave to appeal and the second which involves ground seven, the admissibility of the medical reports. I will now deal with each of those issues.

Leave to appeal

[42] J seeks leave to appeal the following findings under the CPMIP Act, 11 and a half years out of time. Those findings are:

(a) that J was involved in the offending under ss 9 to 13;

(b) that J was unfit to stand trial under s 14; and

(c) J's disposition made under s 25(1)(b) of the CPMIP Act.

[43] As the two charges were both summary offences commenced before the Criminal Procedure Act 2011 came into force in July 2013,[36] the Summary Proceedings Act 1957 appeal process applies.

[44] Under s 115 of the Summary Proceedings Act, a general right of appeal to the High Court was available. Any such appeal had to be filed within 28 days of sentencing or the date of the relevant decision.[37] In this case, it would have been 28 days after the date on which the finding of unfitness was made, or the date of the disposition under s 25 of the CPMIP Act.

[45] The High Court may, on an application, extend the time for filing a notice of appeal.[38] In *Cleggs Ltd v Department of Internal Affairs*, Thorp J articulated the standard required under the Summary Proceedings Act for leave to be granted to extend time:[39]

> (i) That the onus is on the applicant to show special circumstances why the decisions and sentences should not stand;
>
> (ii) That the discretion is given essentially for the purpose of avoiding miscarriages of justice;
>
> (iii) That all the circumstances of the particular case should be considered in deciding whether sufficient grounds have been shown; but
>
> (iv) That one of the matters which must be established is that there is a real likelihood that an appeal would succeed if leave is granted; some of the authorities going to the stage that the likelihood must extend to the point of establishing a probability of success.

[46] Recently, in *Pepperell v Police*, Ellis J considered the overall question of whether it is necessary in the interests of justice to grant leave.[40] The Judge noted that there are a variety of considerations relevant to the interests of justice, but the essential factors are the length and reason for the delay and the merits of the proposed appeal.[41] In *R v Lee*, the Court of Appeal stated that a long delay is a major factor weighing against leave and when it is unexplained, it will usually be decisive.[42]

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36 Criminal Procedure Act Commencement Order 2013, cl 2.
37 Summary Proceedings Act 1957, s 116(1).
38 Section 123(1).
39 *Cleggs Ltd v Department of Internal Affairs* HC Auckland M1032/84, 5 September 1984 at 2.
40 *Pepperell v Police* [2016] NZHC 2654.
41 At [17].
42 *R v Lee* [2006] 3 NZLR 42 (CA) at [115].

[47] J relies on the reasoning of the Court of Appeal in *Lawler v R*, where appeals arose from convictions in 1987, 1990 and 1994 respectively, on the question of whether the appellant was fit to stand trial.[43] The hearing took place in 2013 and the Court of Appeal considered that owing to the appellant's cognitive deficits, he did not realise he was able to appeal until his current counsel advised him of his appeal right. Because the assessment of the merits of the appeals overlapped with the assessment of the applications for the extension of time, the Court proceeded to consider the merits of both in the appeal hearing and granted an extension of time.[44].

[48] I propose to follow the course of the Court of Appeal in *Lawler* and will consider the application for extension of time for appeal together with the assessment of the merits of the appeal.[45]

Inadmissibility of medical evidence

[49] J claims that the reports of Dr Sinclair, Dr Fernandez, Dr Burgess, Dr Duff and Ms Breen were inadmissible before the District Court, as they were in breach of s 33(3) of the Evidence Amendment Act (No 2) 1980 (EAA). As these health assessor reports were considered by the District Court and formed the basis for the Court's unfitness finding and ultimate disposition order, this Court must also consider them on appeal.[46]

[50] Further, as the Crown submits, because this appeal is a rehearing and involves the Court reaching its own view on any questions of fact,[47] including hearing new evidence if required,[48] the admissibility of the medical evidence should be dealt with as a preliminary matter. J submits that no consent was ever obtained from him, or from anyone on his behalf, to refer to "protected communications" and incorporate

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43 *Lawler v R* [2013] NZCA 308.
44 At [65].
45 *Lawler*, above n 43.
46 Criminal Procedure (Mentally Impaired Persons) Act 2003, s 17(3) stipulates the Court on appeal must consider the evidence of two health assessors. Further, the Summary Proceedings Act 1957, s 119(2) provides that the evidence taken in the District Court shall be brought before the High Court.
47 Summary of Proceedings Act 1957, s 119(1) and (2).
48 Section 119(3).

them in reports for the Court. Further, no consent was sought or obtained at the time of making the reports.

[51] Section 33 of the EAA, since repealed, but in force until 2007 provided:[49]

> **33 Disclosure in criminal proceeding of communication to medical practitioner or clinical psychologist**
>
> (1) Subject to subsection (2) of this section, [no … medical practitioner and no clinical psychologist shall] disclose in any criminal proceeding any protected communication made to him by a patient, being the defendant in the proceeding, except with the consent of the patient.
>
> (2) This section shall not apply to any communication made for any criminal purpose.
>
> (3) In subsection (1) of this section, **protected communication** means a communication made to a … medical practitioner or a clinical psychologist by a patient who believes that the communication is necessary to enable the … medical practitioner or clinical psychologist to examine, treat, or act for the patient for—
>
> (a) Drug dependency; or
>
> (b) Any other condition or behaviour that manifests itself in criminal conduct;—
>
> but does not include any communication made to a … medical practitioner or a clinical psychologist by any person who has been required by any order of a Court, or by any person having lawful authority to make such requirement, to submit himself or herself to the medical practitioner or clinical psychologist for any examination, test, or other purpose.
>
> …

[52] As the authorities demonstrate, the courts have strictly interpreted s 33, as it conferred an absolute privilege in criminal proceedings.[50] This distinguished s 33 from the general rule relating to special relationships of confidence, where the Court could exercise a discretion as to admissibility, under s 35 of the EAA. In *R v Gulliver*, the Court of Appeal cautioned that s 33 should not be expansively read.[51]

[53] There are two parts to this preliminary ground of appeal. The first is the issue of consent and the second relates to the substance of the health assessors' reports.

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49 Repealed on 1 August 2007 by the Evidence Act 2006, s 215.
50 See, for example, *R v Gulliver* CA 51/05, 9 June 2005 at [35] and [43].
51 *Gulliver*, above n 50, at [35] and [43].

(a) Consent

[54] Dr Ellis submits that the reports of the medical assessors were in contravention of s 33(3) of the EAA. He relies on *R v D*, a judgment of the full court of the Court of Appeal, where a defendant was convicted of a serious sexual offence and qualified for a sentence of preventive detention.[52] Two medical reports were commissioned to assist the Judge at sentencing. The Court of Appeal held that the report from the psychiatrist, who was treating the accused at the time, was a protected communication under s 33 of the EAA, because the report was based upon privileged communications with the defendant and the defendant had not consented to the disclosure of those communications. The Court held that consent under s 33 of the EAA required specific and informed consent to the disclosure of a past communication.[53] The test was not whether the accused chose to make a protected communication, knowing that it might be disclosed in future. The Court held the report from the treating doctor should not have been admitted as part of the sentencing process.

[55] I consider that there is a key distinction between *R v D* and J's case. The District Court commissioned J's assessment reports from Ms Breen, Dr Fernandez and Dr Burgess, none of whom were "treating" J at the time. Psychiatrists and clinical psychologists, who undertake assessments are doing so on an independent basis, in this case by Court direction under statute, and have an obligation to present J's previous medical history, referred to as a patient's longitudinal clinical history,[54] as part of their independent report.

[56] In my view, their reports differ from that of the psychiatrist in *R v D*, who was treating the defendant and had access to privileged communications as a result of engaging with the accused in treatment.

[57] I address this point in further detail below, in considering each of the health assessors' reports.[55]

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52 *R v D* [2003] 1 NZLR 41 (CA).
53 At [45].
54 At [373] of this judgment.
55 At [73]–[80] of this judgment.

(b) Health Assessors' reports

Dr Sinclair's report

[58] Dr Sinclair is a registered psychologist, who completed a psychological risk assessment on J. He completed a report dated 12 July 2004, after J was referred to him by RIDCA for an assessment of risk issues. Dr Sinclair recorded that at the time of the assessment, J was resident in the Solway Residence at Tuakau, facing three criminal charges and that he was to attend the Mason Clinic for a s 121 CJA report. He was to reappear in Court on 14 July 2004.

[59] The sources of information upon which Dr Sinclair relies, include a cognitive assessment from November 2002, a Dual Disability Services report from January 2004,[56] a behaviour management plan from August 2003 and a preliminary discharge note from Tiaho Mai Mental Health Services in June 2004. Dr Sinclair also obtained J's psychiatric/mental health history from a previous diagnosis by Dr Marks, a psychiatric assessment by Dr Werry, ongoing programming by Arohanui psychological staff, a review from Dual Disability Services and an inpatient assessment at Tiaho Mai.

[60] In addition, Dr Sinclair had interviews with J's caregivers, including his mother, and the principal of Arohanui Special School. Dr Sinclair made professional behavioural observations in the report and gave examples from his interview with J. He summarised key points about J's autism/intellectual disability, including his cognitive abilities, communication, emotional function and empathy. The report concluded with a risk formulation and Dr Sinclair's recommendations, including that a permanent residential placement be found for J, despite his mother's wish to have him home. The management of J's risk at home by his mother alone, was assessed as difficult.

[61] As one would expect with a clinical assessment, the medical history described is contained in previous clinical reports and does not form part of J's "treatment". The behaviour management plan addresses clinically observed risks but unlike the

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[56] Objection is taken to the qualifications of the author of the Dual Disability Services report, Mr Bezuidenhout, by J's counsel.

"protected communications" to the treating psychiatrist in *R v D*, the information relied on by Dr Sinclair came from previous assessments, diagnoses and reviews. The behaviour management plans, ongoing programming and reviews form part of the clinical management of J at specific institutions.

[62] The circumstances surrounding the use of Dr Sinclair's report also militate away against the maintenance of privilege in the report for these reasons:

(a) The report was provided to Tanya Breen, a consultant clinical psychologist, who was directed to comment on Dr Sinclair's report for the purposes of the District Court, when determining the appropriate disposition for J.

(b) From the correspondence between the Crown solicitor and J's then counsel, it appears that J's counsel wished to rely on Dr Sinclair's report at the hearing and the Crown solicitor sought disclosure of the report.

(c) In a brief of evidence from the Compulsory Care Coordinator, Mr Tenari, it appears that J's mother and a support person from Justice Action Group, Mr Burgering, wanted a second opinion on where J would be best placed and sought Dr Sinclair's assessment to determine this.

[63] I accept the Crown's submission that it is difficult to maintain privilege in Dr Sinclair's report, when it was made available to the Court; was subject to comment from Tanya Breen; was completed with the cooperation of J's mother and J's caregivers; and was relied on by J's counsel. These circumstances strongly indicate that any privilege or protection under s 33 even if it had existed, had been waived.

Dr Duff's report

[64] Dr Duff is a consultant psychiatrist with the Intellectual Disabilities Offender Liaison Service (IDOLS), being part of a team from the Mason Clinic. Dr Duff reviewed J and his medication on a regular basis between March and May 2005. Dr Duff undertook her consultations in the presence of J's mother and met with Tanya

Breen in conjunction with the other members of the IDOLS team from the Mason Clinic. Dr Duff wrote two letters to the presiding Judge at the Manukau District Court on 16 and 30 May 2005 respectively, addressing the options of disposition under the IDCCR Act, particularly in relation to any potential hospital level orders and possible transition to the High Care Unit in the Mason Clinic.

[65] Dr Ellis submits that Dr Duff's letters to the District Court Judge contain information obtained from her "treatment role" and such information derived from a clinical file, "to the detriment of a patient should not be given to the Judge by treating physicians without consent". Dr Ellis submits J's consent is not recorded. Dr Ellis also expresses concern that a "bundle of reports from Dr Duff", including her earlier reports to J's GP and weekly clinical reviews, appear to have been placed on the District Court file.

[66] Dr Duff wrote two letters to the District Court dated 16 and 30 May 2005 respectively. No other documents were included with those letters on the Court file. The Crown has explained that any suggestion that other documents may have also been sent to the District Court, arose unfortunately as a result of the way in which the documents were discovered to J's counsel. The documents were disclosed in a way that may have given rise to an impression that those documents were part of Dr Duff's letters. The error was amended in the agreed bundle filed for this hearing, showing the letters as stand-alone documents.

[67] On a perusal of Dr Duff's letters to the presiding District Court Judge, I have found no reference to attachments, as one would expect, if clinical records were being attached to a clinician's letter.

[68] Dr Ellis is correct that Dr Duff's letter to the Judge discloses that J suffers from severe autism and that any change to his routine increases the risk of assaultive behaviour towards staff. However, this is information that was already before the Court, in the disability hearing of 7 February 2005 before Judge Epati, in which he made the finding of J's involvement in the offending and his unfitness to stand trial. Dr Duff was the clinician with an overview of J's care, following J's remand on bail.

[69] I accept the Crown's submission, that in her letters, Dr Duff does not produce any confidential communications between her and J or between J and any other clinician. The letters inform the Court of potential issues arising, if disposition orders were to be made in a particular form. For example, her 16 May 2005 letter requests the Court to authorise Auckland Regional Intellectual Disability Services (RIDS) staff to make arrangements for J's transport to Wellington. In her 30 May letter, Dr Duff asks the Court to defer making an order for one day, to enable Auckland RIDS to make arrangements for J's transport to Wellington.

[70] I do not accept this is an instance of disclosure of a protected communication by a treating clinician but rather, advice to the Court on a disposition order, about the nature of the available facilities in Auckland and the transportation issues which would be authorised as a result.

[71] Although consent is not specifically addressed in Dr Duff's letters, I note again that Dr Duff completed her clinical reviews and assessments in the presence of J's mother. J's mother, who has been J's support person and caregiver for the events leading up to J's offending in 2004 and is J's welfare guardian, appears to be a constant presence throughout the medical assessments. Mr Burgering, from Justice Action Group, also provided assistance to J's mother. The inference can readily be drawn from their respective involvement, that consent has been authorised on J's behalf, in these circumstances.

[72] I do not find that there has been a breach of s 33(3), in the provision of Dr Duff's letters to the Court.

Court-ordered reports of Dr Fernandez, Dr Burgess and Ms Breen

[73] J challenges the admissibility of the health assessor reports of Dr Fernandez, Dr Burgess and Ms Breen, as they have referred to or taken information from Dr Sinclair's risk assessment and Dr Duff. By relying on J's treatment records, Dr Ellis submits these reports all breach s 33(3) of the EAA and are inadmissible.

[74] The starting point for an analysis of admissibility is the purpose of s 33 of the EAA. The Court of Appeal in *R v D* reinforced that the policy of s 33 of the EAA "is

to encourage people to seek treatment which is very much in the public interest."[57] In *R v D*, the psychiatrist was treating D. D's communications with the psychiatrist over the period before the psychiatrist prepared a Court report, were held to be "protected communications", "as they were made by D believing that the communication was necessary for his treatment."[58]

[75] The position is quite different here. I am unable to uphold J's challenge to the admissibility of the above court-ordered health assessor reports for the following three reasons.

[76] First, the reports of Dr Fernandez and Dr Burgess were prepared for the purpose of determining whether J was fit to stand trial, as directed by the Court.[59] Ms Breen's report was prepared for the purpose of determining the appropriate disposition for J, pursuant to a s 23 CPMIP Act order.[60] These reports are covered by the proviso in s 33 EAA, as they were court ordered. The proviso, under s 33(3) of the EAA, provides that a protected communication:

> … does not include any communication made to a medical practitioner or a clinical psychologist by any person who has been required by any order of a Court, or by any person having lawful authority to make such requirement, to submit himself or herself to the medical practitioner or clinical psychologist for any examination, test or other purpose.

[77] The above proviso means that anything discussed in the course of any examination by a court-ordered report-writing clinician is not privileged. All of the reports and evidence of Dr Fernandez, Dr Burgess and Ms Breen come within this proviso to s 33. The Court ordered those reports, including that of Ms Breen, to complete an assessment of J under Part 3 of the IDCCR Act, prior to any compulsory care order being made.

[78] I accept the Crown's submission that all of the other material filed with the District Court, related to J's court ordered IDCCR Act assessment, which would also be covered by the proviso in s 33(3) EAA.

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57 *R v D*, above n 52, at [45]. Section 33 EAA has a corresponding section in the Evidence Act 2006 at s 69.
58 At [44].
59 Criminal Procedure (Mentally Impaired Persons) Act 2003, ss 14(1) and 38).
60 Sections 23(1), 24(1)(b), 25(2) and 38.

[79] Second, there has been no identifiable protected communications from J to the medical practitioners or clinical psychologists. Even if the historic medical records contained "disclosure" of a protected communication, these were not material to the various health assessors' conclusions. This was the conclusion reached by Clifford J in *T v Police*, where he held that there was no explicit reference to or discussion of therapeutic material contained in the report.[61] In J's case, the reports focus on J's clinical history as well as the assessment reports completed by various health professionals. J's previous clinical record forms part of the longitudinal assessment by a health assessor, which is proper clinical practice, particularly as the health assessor is required both by statute and by the Court, to present a professional assessment of J. Risk assessment forms a critical part of the CPMIP Act report process and longitudinal clinical data is essential to such an assessment.[62]

[80] Finally, there is no evidence which suggests that J believed a communication with a medical practitioner or clinical psychologist was necessary to enable them to examine, treat or act for him. There was no intention by J to seek treatment or provide a communication to assist that purpose. I have noted the remark by Dr Burgess, where in advising J of the purpose of the assessment and the limits of confidentiality, J responded that he thought the purpose of this assessment was to help him "get better". Dr Burgess recorded this response, noting that in his view, J lacked the capacity to fully understand the purpose of the assessment. In light of J's inability to understand the consequences of his behaviour, I do not place any weight on that response. Importantly, there is no identification in any report of a protected communication made by J, for the purpose of his seeking treatment.

Conclusion on s 33 EAA

[81] I find that:

(a) the privilege in s 33 does not apply to any part of the reports prepared for the Court, namely those of Dr Fernandez, Dr Burgess and Ms Breen;

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61 *T v Police* HC Wellington CRI-2007-485-37, 17 March 2009 at [268].
62 See Dr Judson's evidence under Part 3 of this decision, at [373].

(b) the report of Dr Sinclair was made available to the Court and was relied on by J's counsel. J's claim for privilege is inconsistent with his counsel's reliance upon it and its disclosure; and

(c) Dr Duff's letters to the District Court did not contain protected communications and were not privileged. They provided the Court with information about the impact of any future order the Court might make.

[82] For completeness, I record that submissions were also made by the Crown that the s 14 CPMIP Act unfitness hearing was not part of a "criminal proceeding," as s 33(1) of the EAA requires. The Crown also submitted the s 25(1)(b) CPMIP Act disposition decision was not part of a "criminal proceeding" and therefore s 33 of the EAA did not apply to the medical reports provided for that. In light of the findings I have made above, the issue of whether s 14 unfitness hearings or disposition hearings under ss 24 and 25 of the CPMIP Act are "criminal proceedings" is not determinative in this hearing and it is not necessary to make such a finding.[63] I do, however, note that in *RIDCA Central v VM* the Court of Appeal described the CPMIP Act as "criminal justice legislation".[64]

[83] I now turn to consider the other grounds of appeal.

Grounds of appeal

Ground 1 – misleading medical evidence

[84] Dr Ellis submits that the health professionals created a fictional or mythological profile of J, that was so prejudicial as to cause a miscarriage of justice. At the heart of this ground of appeal is the allegation that J has falsely been labelled as:

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63 I do note, however, that once a defendant is found unfit to stand trial under s 14 of the CPMIP Act, the ordinary criminal trial process ceases and a decision is made as to alternative disposition under ss 24, 25 or 27 of the CPMIP Act.

64 *RIDCA Central (Regional Intellectual Disability Care Agency) v VM* [2011] NZCA 659, [2012] 1 NZLR 641 at [66(a)].

(a) J is a paedophile and has bizarre sexual fantasies;

(b) being an extremely high risk of physical violence and offending against children with catastrophic outcomes (i.e. J is supposed to be capable of killing a child); and

(c) being an extremely high risk of arson offending.

[85] The essence of J's challenge is that these labels have built a seriously biased and inaccurate pejorative picture of J which has led to unfair hearings and a miscarriage of justice.

[86] The question of relevance to this appeal, is whether any of the alleged inaccuracies misled the District Court in making the finding of J's unfitness to stand trial or at the disposition stage of the proceedings.

[87] Dealing then with each of the alleged inaccuracies, the following should be placed in context.

(a) Sexual violence risk against children

[88] Dr Ellis has highlighted a number of references by the health professionals to J's sexual fantasies about young pre-pubescent girls and boys and offending against children. While there are numerous references to J's impulses to sniff feet of young girls as well as other residents in the group home, Ms Breen, in preparing her risk assessment for the Court in 2005, recorded the conflicting reports of J's sexual history and reached no conclusion as to J's risk of sexually motivated violence.

[89] Although noting the views of other health professionals that there may be a sexual component to J's physical aggression, Ms Breen recorded that J's mother and a Solway Trust employee could not recall instances of J's sexual interest, sexual arousal or masturbation. Ms Breen herself attempted to assess J's sexual knowledge and interest but as she recorded, J was tired and, although cooperative, he was echolalic, highly suggestable and further interview was deemed inappropriate. Ms Breen recorded J's interest in feet and despite others' growing concern that J's foot fantasies

may be linked to his sexuality, Ms Breen recorded that those foot fantasies in his drawings or pictures, often involved force, weapons and restraint.

[90] I accept the Crown's submission that Ms Breen was advising the Court of J's observed behaviours in her risk assessment and that no conclusive view on J's risk of sexual violence could be or was reached.

(b) Physical violence risk

[91] Ms Breen reported in her 4 March 2005 risk assessment, that J's first contact with the police occurred in 2000 "after he tied up a fellow student (female), and wounded the neck and throat (requiring plastic surgery) of a female student at Sir Keith Park School." J's mother brought to Ms Breen's attention that her record of events was incorrect.

[92] Ms Breen checked with the Care Coordinator, Mr Tenari, who had sent the information by way of email. After making further enquiries of the deputy principal of the school, Ms Breen subsequently reported to the Court on 12 May 2005, that J did not tie the student up but on returning to the playground, cut the back of the neck of the female student. The student was taken to hospital by ambulance and needed stitches before returning to school several days later. In her subsequent report of 12 May 2005, Ms Breen thus corrected the previous information and restated her view on J's disposition. Following the information from the deputy principal, Ms Breen stated that it:

> reinforces my belief that [J] can engage in behaviour of a very serious nature, with no apparent triggering events, and that he has no appreciation for the harm that he might cause.

[93] She concluded further, that her previous view that J should receive "community secure" care or "hospital secure" care, if the former was not available, was still her assessment.

(c) Arson risk

[94] A consult liaison nurse, Mr Nicholls, had recorded in a letter that J must be considered to be at an extremely high risk of arson. The letter in which the comment

was made was not before the District Court. Ms Breen took into account Mr Nicholls' letter in preparing her risk assessment of J but did not uphold the suggestion or make any equivalent suggestion that arson was an extremely high risk factor for J. Instead, she focused on J's drawings and conversations in which he had expressed "strong interests in physical violence to people and property, fire setting, and using guns to kill people" and recommended that J be housed in a "damage-resistant" and "fire-safe/arson-proof" physical environment.

[95] The focus of Ms Breen's recommendations are on J's physical aggression, his interest in re-enacting violent movie or television scenes and sniffing feet.

[96] Dr Fernandez and Dr Burgess also identified that J had an interest in fires and explosions, although their observations on this point were limited.

Discussion

[97] Turning then to the District Court findings under appeal, the question arises whether any of the allegations of inaccuracy impacted on the District Court findings.

[98] The District Court's finding under s 9 of the CPMIP Act as to J's involvement in the offending is not affected by J's challenge to the accuracy of the health assessor evidence. The summary of facts and evidence given (by way of prepared witness statements) were sufficient to establish J's involvement in the offending. From the records still available, it appears that the prosecution did not introduce or need medical evidence to prove J's involvement in the offence. The alleged inaccuracies did not impact the District Court's s 9 CPMIP Act finding.

[99] In relation to the District Court's finding under s 14 of the CPMIP Act as to J's unfitness to stand trial, the Court had ordered and considered health assessor reports from Drs Burgess and Fernandez in making this decision. However, the alleged inaccuracies did not impact the District Court's finding under s 14 because both of

these reports supported a conclusion J was unfit to stand trial because of a mental impairment.[65]

[100] The alleged inaccuracies were, however, potentially relevant to the District Court's disposition hearing and order under s 25(1)(b) of the CPMIP Act to determine what order was appropriate for J under that Act. At the time of selecting the appropriate level of care for J, J's current risk and history of behaviour were relevant to the Court's decision and properly formed the focus of the Judge's consideration.

[101] In his oral judgment, Judge Kerr referred to the evidence of the health assessors.[66] The Judge also specifically noted, that J's counsel accepted that J needed to be dealt with under the CPMIP Act and the IDCCR Act. He said:[67]

> There can be no question, and this is accepted by Mr Simpson for [J], that [J] is a person who needs to be dealt with by the appropriate legislation.

[102] Any concern that inaccurate recording may have misled the Court, can be assuaged by the fact that Ms Breen did ensure the Court had a correct and accurate record before it and that Ms Breen's reports and the correction were prepared in advance of the disposition hearing on 8 February 2006. Dr Ellis' submission that the inaccuracies were reported, with little if any opportunity for J to refute them, cannot be upheld. J's mother did in fact bring the error in Ms Breen's first report to Ms Breen's attention and this was ultimately corrected.

[103] Although it is proper to ensure that incidents recorded in medical notes are accurate and have a proper evidential base, the matters complained of did not feature in any prominent way in the material before the District Court and I am satisfied that the inaccuracies, such as were contained in some of the material highlighted by Dr Ellis, were not material in the Court's determination and did not mislead the Court or misrepresent J's profile. This ground of appeal is dismissed.

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65 This being the threshold test required under the Criminal Procedure (Mentally Impaired Persons) Act 2003, s 14.

66 *Disposition decision*, above n 30, at [4].

67 At [1].

Ground 2 – no s 9 hearing or reasons

[104] J appeals the s 9 CPMIP Act decision, that on the balance of probabilities, he caused the acts of the offences of wilful damage and being unlawfully in a yard. Dr Ellis submits that the only record of the s 9 hearing are handwritten copies of notes, which have been provided to the Court in a reconstructed agreed bundle of documents for this appeal hearing. The submission is that the absence of a s 9 judgment (and a s 14 judgment, which is dealt with in the next ground of appeal) causes actual prejudice to J, resulting in a serious miscarriage of justice and preventing a fair appeal.

[105] At the time of the hearing a bundle of documents with the District Court record of hearing sheets were made available to the Court. The record of hearing records the following date entries:

2 November 2004	FRBTC[68] to 7 February 2005 for disability hearing (2 hours).[69]
7 February 2005	Disability hearing. Finding of involvement s 9. Finding of disability (unfit to plead and stand trial) p. s. 7. Section 23(2)(A) FROB[70] 7/3/05. To reside @ Solway Trust, 22 Tuakau Road. Epati DCJ. 7 February 2005

[106] In addition to the hearing record sheets, the police prosecution file was obtained and the prosecutor's notes were included in the agreed bundle. From the prosecutor's notes, the following is recorded:

> Def found under a disability by J/Epati on 7/2/05 after being found "involved".
>
> So now remanded on bail to find "suitable placement" per s 23 of the new Act (Criminal Procedure (Mentally Impaired Persons) Act 2003).
>
> Remand = 7/3/05.
>
> Signed 7/2/05.

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68 Further remand on bail to continue.

69 This notation was recorded on the hearing record sheets for both offences of wilful damage and unlawfully in a yard.

70 Further remand on bail.

[107] On the reverse side of the police prosecutors note is a further record entitled "Involvement hearing". This records:

> INVOLVEMENT HEARING
>
> [J's mother] (mum).
>
> Gaznafar BUKSH (neighbour) ON WAY.
>
> C/WESTERLUND
>
> S/Down – ready to proceed.
>
> Two Dr reports attached.
> Dr Burgess dated 13/9/04
> Dr Fernandez dated 13/7/04.

[108] Dr Ellis contends that there is no record of any formal statements, oral evidence, or any other evidence or reasons of how Judge Epati or Judge Sharpe reached the conclusion of J's involvement. This, Dr Ellis argues, is contrary to s 13(1) of the CPMIP Act, that the Court must record its finding on the defendant's involvement, if satisfied of the matters under s 9, namely the defendant's involvement in the offence.

Discussion

[109] It is correct that no reasons are given by Judge Epati on 7 February 2005, of his finding under s 9 of the CPMIP Act. It is clear however, that from the hearing record sheet, the Judge did record his finding under s 9, as required by s 13 of the CPMIP Act. The police records clearly indicate that the matter was set down for hearing and that the three witnesses, including one "on the way" were to give evidence, as demonstrated by the contents of their respective witness statements. This evidence is consistent with a finding that J was involved in the alleged offending on the balance of probabilities.

[110] I consider that the Judge did make a finding based on cogent evidence, which met the threshold of a finding on the balance of probabilities. Although the Judge did not give full reasons for his finding, he did record the finding and took further steps to order that inquiries be made, to determine the most suitable method of disposition, under ss 24 and 25 of the CPMIP Act.

[111] I am unable to find that there was a miscarriage of justice or severe prejudice caused to J for these reasons:

(a) J was represented by counsel throughout the period from his first appearance on 9 June 2004 through to the disability hearing (ss 9 and 14 CPMIP Act) on 7 February 2005.

(b) J's mother, as his principal caregiver and welfare guardian, was a witness in the hearing and her brief of evidence attests the sequence of events relevant to the charges. If there were a miscarriage of justice, it is reasonable to infer J's mother, would have raised her concern, as she did with Ms Breen's 4 March 2005 report. Instead, she participated in the hearing. I also note that J's mother has not provided evidence in this hearing, to the effect that although she was a witness at the involvement hearing, it either did not take place or was unfairly conducted.

(c) The CPMIP Act came into force on 1 September 2004 during the time sequence between J's first appearance and the disability hearing.[71] Any oversight by the Judge to follow precisely the process stipulated by the CPMIP Act, with its introduction of ss 9 and 14 hearings, must be viewed with some understanding of new procedures bedding down in the new approach to disability hearings. The weight of evidence regarding J's involvement in the charges, leaves me in no doubt that no miscarriage of justice has occurred here, nor has there been any unfairness to J.

[112] For completeness, I record that Dr Ellis made submissions about the informal reconstruction of the Court file, the case and the absence of a proper process to reconstruct the file. He submits the case should have been called in open Court and the parties invited to participate in the reconstruction, when a Court file has been

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[71] Criminal Procedure (Mentally Impaired Persons) Act Commencement Order 2004, cl 2.

destroyed.[72] Dr Ellis also made submissions on the Doctrine of Spoliation, being a remedy for the District Court's error, in destroying a Court file. The latter is the subject of a ground of judicial review and I will address these submissions in relation to the destruction of the Court file in Part 4 of the judgment, where I consider the judicial review grounds.[73]

[113] In relation to the reconstruction of the file for this hearing, I consider that counsel have proceeded correctly in obtaining the documents that were before the District Court, including the record of hearing sheets and, as a corroborative form of documentation, the police prosecutor's file. I do not consider there has been any unlawful "editing" of the reconstructed Court file and no miscarriage of justice has occurred in the hearing of this appeal.

Ground 3 – no s 14 hearing or any record or reasons

[114] This ground of appeal proceeds in the same way as the ground advanced for the s 9 hearing. Dr Ellis contends that in the absence of a judgment, an adverse inference should be drawn that the legal test used in the s 14 hearing was inadequate. He submits that no record of any s 14 hearing has been located and no reasons for any or all of the s 14 findings of mental impairment, intellectual disability, or unfitness to stand trial were given. The absence of a judgment, Dr Ellis submits, causes actual prejudice to J, a serious miscarriage of justice and prevents a fair appeal. Again, Dr Ellis submits the deliberate and unlawful destruction of the Court record is an aggravating feature of the prejudice caused and is pleaded further in the judicial review proceedings.

[115] In the absence of any record, Dr Ellis submits that it is possible that the Judge was misled by the health assessors in reaching a s 14 finding and the Judge failed to conduct a rigorous examination and test the evidence. This, he submits, is in breach of the rigorous examination rule as required by the English Court of Appeal in *R v*

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72 Human Rights Committee *Views: Communication No 230/1987* XLIII CCPR/C/43/D/230/1987 (1 November 1991) (*Henry v Jamaica*); *Davids v S* (A571/12) [2013] ZAWCHC 72; and Hawke's Bay Earthquake Act 1931, s 12.

73 At [601]–[608] of this judgment.

Walls and the New Zealand Court of Appeal in *SR v R*.[74] It was not a fair s 14 or s 25 hearing, Dr Ellis submits.

Discussion

[116] As the same points were canvassed in my reasons above, for ground two, I will canvass the main points in brief. The outcome of the disability hearing on 7 February 2005 is recorded in the hearing record sheet, where the Judge records a finding of disability (unfit to plead and to stand trial). The Judge does not refer to s 14 but instead, refers to s 7.[75] I consider this is a record of his finding of unfitness to stand trial as envisaged under s 7 of the CPMIP Act.

[117] It is correct that there are no full reasons given by the Judge on 7 February 2005, in reaching his finding of J's disability. However, it is clear, that in preparation for the hearing and provided to the Judge at the hearing, were "two doctor reports", as the police prosecutor recorded. They were the reports of Dr Burgess and Dr Fernandez, dated 13 September 2004 and 13 July 2004 respectively.

[118] For the same reasons I reached under Ground two of this appeal, I find this ground of appeal fails. I am satisfied that the Judge did hear the evidence and, unlike the South African case of *Davids* where there was no record of the Court file, the detailed reports of Dr Burgess and Dr Fernandez set out clearly the basis for making a disability finding in respect of J.[76]

[119] I am also satisfied that the Judge, having heard or considered that evidence (and of course there is no formal record of whether they were called or whether the evidence was accepted) the Judge proceeded to order inquiries under s 23(2)(a) of the CPMIP Act for the purpose of determining the appropriate disposition under ss 24 and 25 of the CPMIP Act.

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74 *R v Walls* [2011] EWCA Crim 443, [2011] Cr App R 6 at [38]; and *SR v R* [2011] NZCA 409, [2011] 3 NZLR 638 at [164].

75 Section 7 of the CPMIP Act describes when a finding of unfitness to stand trial may be made.

76 *Davids*, above n 72.

[120] Again, for the reasons cited above, there is no evidence to support J's challenge that he is prejudiced in his appeal or that a miscarriage of justice has occurred. J was represented throughout by counsel and his mother, who is J's welfare guardian, provided a witness statement for the prosecution. If a miscarriage of justice has occurred, then J's mother had an opportunity to give evidence about her concerns over this hearing and has not done so.

[121] I accept the Crown's submission that any prejudice to J's appeal is caused by the fact it is being advanced 11 or more years out of time. The submissions on the "unlawful" destruction of the Court file are dealt with further under the judicial review grounds.[77] This ground of appeal also fails.

Ground 4 – no intellectual disability

[122] Under this ground of appeal, J challenges the s 14 finding of mental impairment (without conceding there was a s 14 finding), that J was wrongly found to be suffering from an intellectual disability and should never have been detained as a care recipient. The basis of this ground is that J was prescribed a number of anti-psychotic drugs, which affected his cognitive ability, after which he was given an IQ test. Thus, J's subsequent detention as a care recipient is claimed to be unlawful.

Discussion

[123] There is no application for leave to adduce further evidence on this appeal by or on behalf of J,[78] to advance the proposition that J's cognitive abilities were affected by psychotropic medication. Evidence was adduced from Dr Olive Webb on behalf of J under the s 102 inquiry hearing before this Court, where the inquiry as to whether J had an intellectual disability was canvassed. Dr Webb gave evidence that psychotropic medication can depress IQ scores and cognitive functioning but that J was "quite chirpy bordering on playful", despite his medication. This is discussed under Part 3 of this judgment and does not advance this ground of appeal.[79]

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77 At [601]–[608] of this judgment.
78 Summary Proceedings Act 1957, s 119(3).
79 At [336]–[339] of this judgment.

[124] In relation to this CPMIP appeal however, there was cogent evidence before the District Court relating to J's intellectual disability. The first is Ms Breen's specialist assessment, which found J to be intellectually disabled. This was accepted by Judge Kerr in the disposition hearing. Further, Mr Woodcock, a registered psychologist, also provided a report as a specialist assessor under the IDCCR Act. He did not test J's intellectual functioning, but supported the finding that J appeared to be intellectually disabled. His report was dated 7 February 2006 and was sent to the presiding Judge, Judge Kerr.

[125] There is no evidence in those reports or before the District Court, that gives rise to a concern that any test of J's intellectual disability was affected by his anti-psychotic medication. I can see no reason to interfere with the finding by Judge Kerr. I therefore dismiss this ground of appeal, but note that under s 102 of the IDCCR Act, I have conducted an inquiry into J's intellectual disability and the evidence in respect of J's mental impairment, which is discussed under Part 3 of this judgment.

[126] I record for completeness, that Dr Ellis referred to the evidence proceeding from another psychologist, Richard Duncan, in the 2017 Family Court extension hearing. The question on this appeal is whether there was sufficient evidence for a District Court Judge to make sound findings under ss 14, 24 and 25 of the CPMIP Act, in respect of any IDCCR Act care placement. The evidence of Dr Duncan is not before the Court on this appeal. It is out of context and is not a relevant consideration on this appeal. This ground of appeal fails.

Ground 5 – J's other defences not considered

[127] In this ground of appeal, Dr Ellis submits that no consideration was given by the Court, prosecution or defence to whether J was temporarily insane or had any other defence known in law. In making this submission, he canvasses a number of the psychiatric assessments, in which references have been made to J's "catatonic state" or "autistic catatonia" and "autism". As autism is now contained in the DSM-V[80] as a

[80] DSM-V is the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

mental disorder, Dr Ellis urges that no investigation was undertaken of other possible defences such as a plea of not guilty and a temporary insanity defence.

Discussion

[128] An inquiry into alternative defences for J's "offending" is irrelevant, because J has been found unfit to stand trial. This means the normal criminal process, with the entry of convictions and sentencing does not progress. The CPMIP Act, as I have described above,[81] triages a defendant with mental impairment.

[129] Following a disability finding, inquiries are made as to appropriate disposition, depending on the type or manner of disability. By way of contrast, if a defendant is fit to stand trial an insanity defence is still available at trial.[82]

[130] I also accept the Crown's submission that this ground of appeal is in effect a challenge to defence counsel's competence and there is no evidence to substantiate such a claim, nor any case made out. Again, J was represented by counsel throughout the process and no steps have been taken to impugn counsels' competence. This appeal ground also fails.

Ground 6 – undue delay

[131] Under this ground of appeal, J seeks a stay of proceedings for undue delay because inquiries under s 23 of the CPMIP Act were not carried out within 30 days after the date of the order under which the inquiries were initiated. The basis for this ground is that the reports from Drs Fernandez and Burgess were completed in 2004 and a further report by Ms Breen was completed by September 2005, but the mandatory disposition hearing under s 25 of the CPMIP Act did not occur until 8 February 2006. This was beyond the mandatory 30-day period, which expired in October 2005. Dr Ellis submits that J was under "house arrest" with a 24-hour curfew, unless he was with his mother, and was arbitrarily detained at Solway Park.

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81 At [15] of this judgment.
82 See Criminal Procedure (Mentally Impaired Persons) Act 2003, s 20.

Discussion

[132] Following the disability hearing on 7 February 2005, Judge Epati made an order under s 23 of the CPMIP Act on the same day, ordering bail under s 23(2)(a) for the purpose of making inquiries under that section. Those inquiries were completed within 30 days, when Ms Breen prepared her first specialist assessment report dated 4 March 2005.

[133] Section 24(1) of the CPMIP Act stipulates that the Court must consider the circumstances of the case and the evidence of one or more health assessors as to whether a defendant should be detained under the MHCAT Act or under the IDCCR Act, "[w]hen the Court has sufficient information on the condition of a defendant found unfit to stand trial".

[134] There were a number of reasons for the delay in determining the appropriate disposition for J and in providing the Court with "sufficient information" on the most appropriate placement for J. J was bailed to Solway Trust, following the disability hearing. This was not a secure accommodation provider. A dispute arose over whether secure compulsory care for J should be ordered under s 25 of the CPMIP Act and if so, where should he be placed. It is plain from Dr Duff's correspondence to the Court that there was a likelihood of J being transferred to Wellington if the Court made a secure care order in May 2005.

[135] The concern about J's placement in Wellington was raised by the Justice Action Group advocate, Mr Burgering, who wrote to the presiding Judge on 14 March 2005, advising that he had been actively involved with J and his family since this matter began and he was helping J's mother, who "appears to be the centre of his world", to get the help that her son needs. In this letter, he asked the Court to take into account his submission that J be permitted to remain at Solway Trust, as it can provide the level of supervision and service required, although it is less restrictive than the secure care. I note from the Manukau prosecutor's file record of 21 March 2005, that:

> [Judge] Epati didn't want to deal with it as final care not resolved. [J] may end up in Mason Clinic!
>
> Put off for more reports.

[136] Clearly the dispute over final placement for J continued up to the date of hearing, when the Court received Mr Woodcock's report. He suggested that J's continued residence at Solway, as a voluntary client, would be most appropriate. He noted that he was not undertaking his assessment in his role as a specialist IDCCR assessor but rather as a clinician with some 15 years clinical assessment experience for a range of services, including the courts.

[137] The tension over J's placement is apparent in Judge Kerr's judgment, where he described the likely placements for J, being Solway Trust and Te Roopu Taurima.[83] It is plain, from the chronology of events since the disability hearing on 7 February 2005 to the disposition hearing on 8 February 2006, that any delay was principally due to attempts to find the most appropriate placement for J.

[138] There were other factors which must also be taken into account in the delay between disability and disposition hearings:

(a) J's counsel, Mr Singh was granted leave to withdraw in May 2005. Mr Simpson took over as counsel in June 2005.

(b) On 2 August 2005, the Judge was unavailable and the matter was adjourned until 15 September 2005 for the updating report from Ms Breen.

(c) Ms Breen was not immediately available to provide an updating report. Her re-assessment report was dated 27 October 2005.

[139] All of these occurrences explain the delay between the charge and the ultimate disposition. The Court cannot proceed to make important disposition findings under ss 24 and 25 of the CPMIP Act, until it has sufficient information on the condition of a defendant found unfit to stand trial.[84] In this case, the principal concern was the ultimate placement of J.

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83 *Disposition decision*, above n 30, at [8]–[12].
84 Criminal Procedure (Mentally Impaired Persons) Act 2003, s 24(1).

[140] For completeness, I consider s 25(b) NZBORA is not applicable to this disposition hearing. The right to be tried without undue delay is not applicable where the charge cannot be determined, because the defendant is unfit to stand trial. Further, s 24(1) of the CPMIP Act requires the Court to have sufficient information on the condition of a defendant and in this case, the initial inquiries were requested and received within the statutory period under s 23(4). Ms Breen's report led on to further inquiries and receipt of the subsequent health assessors' reports, as set out above.

[141] This ground of appeal also fails. The delays were for proper purposes and did not become a form of "preventive detention" as Dr Ellis submits. They were not manifestly excessive and a stay of proceedings is not appropriate or justified.

Ground 8 – s 25 CPMIP Act disposition was unlawful

[142] Under this ground of appeal, J challenges the s 25 hearing and ultimate disposition. Dr Ellis submits the s 25 hearing was perfunctory, with little regard for detail or reasons and either it was flawed or inadequate reasoning that led to Judge Kerr's finding of an intellectual disability. Further, he submits, if no previous finding of mental impairment was made, a s 25 hearing was not lawfully permissible. The disposition of two years secure care, Dr Ellis submits, is manifestly excessive and disproportional, being eight times the maximum sentence available for a person without a disability for the two summary offences for which J was convicted. J seeks that the disposition is set aside or J must be released.

Discussion

[143] For reasons addressed under Ground three,[85] I have already found that there was a s 14 hearing in which Judge Epati made a determination that J was mentally impaired. He recorded that he made a finding of disability, such that J was unfit to plead and stand trial. Following the disability hearing on 7 February 2005, the matter came before Judge Kerr on 8 February 2006. Judge Kerr made it plain that he sought to make the least restrictive order that would meet J's interests in receiving appropriate

[85] At [116]–[117] of this judgment.

care and treatment in a minimally restrictive setting and the public interest in reducing J's risk to others.[86]

[144] Where a finding of unfitness to stand trial has been made, as Judge Epati did on 7 February 2005, the next step is whether a special patient or special care recipient order is made under s 24(2) of the CPMIP Act and if such an order is not necessary, the Court must then make one of the orders in s 25(1).

[145] In making an order under s 25(2)(b) of the CPMIP Act, Judge Kerr paid particular attention to J's interests and the degree of security necessary under that order. It is clear to me from Judge Kerr's judgment, that he took into account the relevant considerations of each disposition option, even though he did not laboriously recite the reasons supporting each disposition option under s 25(1).

[146] The Judge ensured that before making an order under s 25(1)(b), he satisfied himself on the evidence of one or more health assessors that J had an intellectual disability and that he had been assessed under Part three of the IDCCR Act.[87] From those considerations, he was satisfied that J had to receive care under a care programme completed under s 26 of the IDCCR Act.

[147] It is true that the Judge conflated a s 14 and a ss 24/25 consideration, when, as I have found, a finding on mental impairment had already been made. However, with the recent introduction of the CPMIP Act at the time of the disposition hearing, I consider Judge Kerr was being prudent and cautious in ensuring that all the relevant reasons were canvassed, before he turned his attention to the type of care order to be made. The Judge reached that conclusion juxtaposing the two options of a secure care order or an order which would enable J to remain where he was. He said:[88]

> It seems to me quite clear that [J] has to receive care under a care programme. The contest, if that is the right way to describe it, is whether I should make a secure care order or an order which would enable [J] to remain where he is with support from the Ministry of Health for his current caregivers.

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86 *Disposition decision*, above n 30.
87 At [6].
88 At [7].

[148] The Judge visited the "two competing facilities" and carefully considered the most appropriate for J's condition and his circumstances. He then made an order that J be held in a secure facility pursuant to s 25(1)(b) for two years, noting specifically, that applications to review the order can of course be made in terms of the relevant legislation.[89]

[149] I am unable to uphold this ground of appeal, as I consider that the disposition orders were lawfully made and the length of J's stay was not arbitrary.[90] The length of stay is expressly authorised by the IDCCR Act, being two thirds of the maximum length of such an order.[91] There have been subsequent reviews and eight extensions of the order, which reinforce the justification for Judge Kerr's decision.

Ground 9 –CPMIP Act is discriminatory

[150] Under this ground of appeal, which has also been pleaded in the judicial review proceedings, J claims that he was treated in a discriminatory way under the CPMIP Act. J appears to seek a form of declaration that the IDCCR Act and CPMIP Act are inconsistent with international conventions, the Statute of Westminster 1275 and the Magna Carta, as well as being inconsistent with the NZBORA. Dr Ellis argues J was treated in a discriminatory way by reason that he was intellectually impaired and/or autistic.

Discussion

[151] In the context of this CPMIP appeal, I do not consider there is an available remedy for J's claim. It is a ground which I canvass under Part 4 of this decision, in the judicial review proceedings.[92] The wider considerations of the international conventions and other constitutional statutes, as well as the NZBORA, are considered in that context.

[152] In the context of this appeal, I find that:

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89 At [15].
90 New Zealand Bill of Rights Act 1990, s 22.
91 Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 46(2).
92 At [506]–[573] of this judgment.

(a) The CPMIP Act process is not discriminatory as found by the Court of Appeal in *Ruka v R*.[93] I acknowledge Dr Ellis' challenge to the validity of *Ruka*, but I reject this and find it remains relevant and authoritative on this point.[94]

(b) There is no available remedy for J's claim in this criminal appeal. J was treated in accordance with the relevant statutes, the CPMIP and IDCCR Acts, and those statutes apply, even if they are described as "discriminatory". This ground of appeal also fails.

Conclusion

[153] I have considered J's leave to appeal out of time, alongside a consideration of the likelihood of success in this appeal. In canvassing the grounds of appeal, I consider they fail and have no chance of success. There has been no miscarriage of justice in J's case and I am satisfied that the findings of his involvement in the offence, his unfitness to stand trial, his mental impairment and the ultimate disposition in an IDCCR Act secure facility were safe and are valid findings.

[154] It is not in the interests of justice to reopen these summary criminal proceedings against J 12 years later or to grant J leave to appeal out of time. J is not prejudiced by his leave to appeal being declined, as he may challenge his continuing care orders through opposing extension applications and by appealing adverse Family Court findings, which he has done in this hearing, together with an application for an inquiry under s 102 of the IDCCR Act.

[155] Although Dr Webb's evidence is not before the Court for the purposes of this CPMIP appeal, it is reassuring, that J's own expert concluded after her clinical assessments, that J was not fit to plead and that J could have little understanding of the Family Court review proceedings.

[156] Even if leave were to be granted, which I do not grant, J's appeal grounds lack merit and his appeal would be dismissed.

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93 *Ruka v R* [2011] NZCA 404, (2011) 25 CRNZ 768 at [86]–[94].
94 See *S v Attorney-General*, above n 10, at [677].

[157] Leave to appeal out of time is declined.

PART 2 - FAMILY COURT APPEAL

[158] This appeal arises from the decision of Judge Goodwin in the Family Court on 27 February 2017.[95] In his decision, the Judge declined to cancel the deferment order of 3 October 2016, as sought by J and granted the Care Coordinator's application to extend J's care order by a period of 18 months. The Judge also varied the care order, from supervised care to secure care. J appeals both orders.

[159] The questions raised by the grounds of appeal are:

(a) Did the Judge wrongly conclude J had an intellectual disability?

(b) Did the Judge apply the wrong legal test and standard of proof to the extension of the care order under s 85?

(c) Did the Judge overlook J's arbitrary detention contrary to s 22 NZBORA?

(d) Did the Judge err in concluding the maximum term of detention was not cumulatively three years?

(e) Did the Judge err in law in finding the specialist assessors' reports and J's drawing were admissible?

(f) Did the Judge err in considering risk assessment trumps the rights of the care recipient?

(g) Did the Judge err in law in not cancelling the deferment order?

(h) Did the Judge err in not placing J at Solway Vision?

(i) Did the Judge err in his interpretation of *RIDCA Central v VM*?[96]

(j) Was the decision to extend J's compulsory care order by 18 months unreasoned?

Approach on appeal

[160] Section 133 of the IDCCR Act provides for a general right of appeal from decisions of the Family Court in relation to that Act.

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95 *Harvey v [J]* [2017] NZFC 1079 [*Goodwin decision*].
96 *RIDCA*, above n 64.

[161] The established principles for general appeals as espoused by the Supreme Court in *Austin, Nichols & Co Inc v Stichting Lodestar* apply to the Family Court appeal.[97] The appellant bears the onus of satisfying the appellate court that its decision should differ from that under appeal.[98] The appellate court is entitled to its own assessment of the merits of the case. Elias CJ summarised the position of the appellate Court:[99]

> [16] Those exercising general rights of appeal are entitled to judgment in accordance with the opinion of the appellate court, even where that opinion is an assessment of fact and degree and entails a value judgment. If the appellate court's opinion is different from the conclusion of the tribunal appealed from, then the decision under appeal is wrong in the only sense that matters, even if it was a conclusion on which minds might reasonably differ. In such circumstances it is an error for the High Court to defer to the lower Court's assessment of the acceptability and weight to be accorded to the evidence, rather than forming its own opinion.

Eligibility criteria

[162] Before the Court can make an order that the defendant is to continue to be cared for as a care recipient, the Court must be satisfied on the evidence of at least one health assessor that the person meets the eligibility criteria.[100] This criteria is that the person concerned:[101]

(a) has an intellectual disability;

(b) has been assessed under the IDCCR Act; and

(c) is to receive care under a care programme completed under s 26 of the IDCCR Act.

[163] First, s 7 of the IDCCR Act defines an "intellectual disability" as follows:

> **7 Meaning of intellectual disability**
>
> (1) A person has an **intellectual disability** if the person has a permanent impairment that—

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97 *Austin, Nichols & Co Inc v Stichting Lodestar* [2007] NZSC 103, [2008] 2 NZLR 141 at [16].
98 At [4].
99 Footnote omitted.
100 Criminal Procedure (Mentally Impaired Persons) Act 2003, s 25(2).
101 Section 25(3).

(a) results in significantly sub-average general intelligence; and

(b) results in significant deficits in adaptive functioning, as measured by tests generally used by clinicians, in at least 2 of the skills listed in subsection (4); and

(c) became apparent during the developmental period of the person.

(2) Wherever practicable, a person's general intelligence must be assessed by applying standard psychometric tests generally used by clinicians.

(3) For the purposes of subsection (1)(a), an assessment of a person's general intelligence is indicative of significantly sub-average general intelligence if it results in an intelligence quotient that is expressed—

(a) as 70 or less; and

(b) with a confidence level of not less than 95%.

(4) The skills referred to in subsection (1)(b) are—

(a) communication:

(b) self-care:

(c) home living:

(d) social skills:

(e) use of community services:

(f) self-direction:

(g) health and safety:

(h) reading, writing, and arithmetic:

(i) leisure and work.

(5) For the purposes of subsection (1)(c), the developmental period of a person generally finishes when the person turns 18 years.

(6) This section is subject to section 8.

[164] Second, throughout the duration of a compulsory care order, the care recipient must be assessed no longer than every six months by a specialist assessor.[102] The purpose of the review is to determine whether the status of the care recipient needs to be continued, changed or ended.[103]

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102 Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, ss 77 and 78.

103 Sections 79 and 82.

Applicable legal principles to the extension of a compulsory care order

[165] Following a review, the care co-ordinator may apply to the Family Court seeking extension, cancellation or variation of an order, as appropriate.[104] In applying to the Court, the care co-ordinator must have regard to the most recent certificate given by a specialist assessor.[105] Likewise, in determining an application, the Family Court must have regard to the most recent certificate given.[106]

[166] If a compulsory care order is due to expire at any time while there is an application to extend the order before the Court, a care co-ordinator may apply without notice for an order to defer, and the Court may defer, the expiry of a compulsory care order.[107]

[167] Any extension to a compulsory care order must be made by the Family Court under s 85 of the IDCCR. Section 85 provides:

> **85 Extension of compulsory care order**
>
> (1) The Family Court may, on the application of the co-ordinator, extend the term of a care recipient's compulsory care order.
>
> (2) If the court extends a compulsory care order for a care recipient no longer subject to the criminal justice system, the court must consider and determine whether the care recipient must receive supervised care or secure care.
>
> (3) The court may order that a care recipient no longer subject to the criminal justice system receive secure care only if it considers that supervised care would pose a serious danger to the health or safety of the care recipient or of others.

[168] Section 85 does not, however, set out any criteria to be applied in determining an extension. The purposes of the IDCCR Act in s 3, as previously set out,[108] are relevant.

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104 Sections 84 to 88.
105 Section 88(1).
106 Section 88(2).
107 Section 87.
108 At [20] of this judgment.

[169] The leading case as to whether to extend a compulsory care order is *RIDCA Central v VM*.[109] There, the Court of Appeal identified that the broader legislative scheme of the IDCCR Act was relevant to determining whether to extend compulsory care orders.[110] The Court noted that the purposes of the IDCCR Act do not refer to risk or to the protection of the community, as could have been expected if the test for extending compulsory care orders was undue risk. The Court observed:[111]

> Rather, the focus is on the availability of appropriate measures to Courts dealing with intellectually disabled offenders, recognising that these measures will also apply in some circumstances to intellectually disabled persons who are no longer subject to the criminal justice system. That indicates that a nuanced approach to the application of these measures is called for. This is confirmed by the explicit statement of the purpose of protecting the special rights of intellectually disabled persons to whom the IDCCR Act applies.

[170] The Court also determined that it was clear the overarching principles of the IDCCR Act, in s 11, applied to Family Court decisions about the extension of a compulsory care order. Section 11 provides:

> **11 Principles governing exercise of powers under this Act**
>
> Every court or person who exercises, or proposes to exercise, a power under this Act in respect of a care recipient must be guided by the principle that the care recipient should be treated so as to protect—
>
> (a) the health and safety of the care recipient and of others; and
>
> (b) the rights of the care recipient.

[171] This balancing approach, between community protection and individual rights, is key to extension decisions. The Court stated that the focus of s 11(b) was on fundamental rights of the individual, particularly those enshrined in the NZBORA.[112] The Court stated:

> [36] What s 11 calls for, therefore, is a balancing of the legitimate interest of the community in protecting the health and safety of the care recipient and others (we will call this the community protection interest) against the liberty interest of the care recipient. That balancing exercise will enable the Court to achieve the purposes described in s 3, because it will lead to the selection of the appropriate compulsory care and rehabilitation option for the care recipient and recognise his or her rights appropriately.

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109 *RIDCA*, above n 96.
110 At [28].
111 At [30].
112 New Zealand Bill of Rights Act 1990, ss 18, 19 and 22.

[172] The Court of Appeal held that an extension order should not be made unless the need to protect the public is sufficiently great to justify the interference with the care recipient's liberty interest.[113] The Court highlighted the following factors are relevant to determining this:[114]

(a) the compulsory care order (including the level of care and the term) must not be disproportionate to the need to protect the community or the care recipient. The balancing approach requires that a compulsory care order is only made if it is the least coercive and restrictive response available to the Court to satisfy the community protection need;

(b) the nature of the original offending is relevant to extension decisions when considering the nature of the risk posed by the care recipient and where the case is finely balanced between the community protection interest and liberty interest;

(c) success or failure of rehabilitation efforts made during the compulsory care order, and the prospect for further rehabilitation, are relevant factors; and

(d) the weight to be given to the liberty interest is not necessarily static. After the care recipient has been subject to a compulsory care order for a substantial period of time, the Judge may determine that greater weight needs to be given to the liberty interest. The longer a care recipient has been subject to a compulsory care order, extension decisions will require ongoing and sometimes increasing justification, because the community protection interest will need to be greater to outweigh the increased weight given to the individual liberty interest.

Considerations for a variation of a compulsory care order

[173] Section 86 of the IDCCR Act governs the considerations for the court to apply on varying a compulsory care order. Importantly, it provides the criteria by which a

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113 At [44].
114 At [59], [69]–[72], [85], [91] and [92].

Court may vary a supervised care order to a secure care order, where supervised care would pose a serious danger to the health or safety of the care recipient or of others. Section 86 provides:[115]

> **86 Co-ordinator may seek variation of compulsory care order**
>
> (1) If the co-ordinator, after consultation with a care recipient's care manager, reaches the view that a variation of any aspect (other than the term) of the care recipient's compulsory care order is desirable, the co-ordinator may apply to the Family Court for a variation of the order.
>
> (2) The court may, on an application under subsection (1), vary a compulsory care order.
>
> (3) On an application under subsection (1) relating to a care recipient no longer subject to the criminal justice system, the court must consider and determine whether the care recipient must receive supervised care or secure care.
>
> (4) *The court may order that a care recipient* no longer subject to the criminal justice system *receive secure care only if it considers that supervised care would pose a serious danger to the health or safety of the care recipient or of others.*

[174] The above legislative provisions and the applicable principles from the authorities are relevant to each of the grounds of appeal.

Fresh evidence on appeal

[175] Although no application for leave to adduce fresh evidence on appeal has been made on behalf of J, reference is made in the appellant's submissions to Dr Webb's "subsequent reversal of her opinion" given at the Family Court hearing in February 2017. Before a Court can consider fresh evidence on appeal, leave to adduce such evidence is required,[116] but this has not been sought by the appellant. Such an application is opposed by the Care Coordinator.

[176] Under r 20.16 of the High Court Rules 2016, the court may grant leave for further evidence on appeal only if there are special reasons for hearing the evidence.[117]

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115 Emphasis added.
116 High Court Rules 2016, r 20.16(2).
117 Rule 20.16(2).

A grant of leave to adduce fresh evidence is made where the evidence is fresh, cogent and credible and was not available at the time of the original hearing.[118]

[177] Dr Webb was called by the appellant to give evidence in the Family Court and she has revisited her evidence in this Court, for the purposes of the s 102 inquiry. Evidence from another of J's witnesses, Professor Barrett has been filed for the s 102 inquiry. Professor Barrett was not briefed nor called at the Family Court hearing.

[178] There was no application for leave to adduce fresh evidence on appeal. Dr Webb's subsequent changed evidential position was not before Judge Goodwin and in the context of this appeal is not relevant.

[179] However, the issue is somewhat moot, because both Professor Barrett and Dr Webb have given evidence in the s 102(2) IDCCR Act inquiry, which was heard at the same time as these appeal proceedings and is considered under Part 3 of this judgment. I therefore make no formal orders on leave.

Grounds of appeal

[180] I turn then to consider each of the grounds of appeal.

(a) Did the Judge wrongly conclude J had an intellectual disability?

[181] J submits that the Judge erred in finding he had an intellectual disability by failing to take into account that:

(a) Dr Webb undertook two IQ tests, one of which assessed J's IQ at 84 and the other at 60, but considered the lower result only;[119] and

(b) neither of the specialist assessors, Dr Thomson nor Ms Jensen, had assessed J's IQ to the standard set in *Harvey v Makitae* but relied on an

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118 See, for examine in the criminal context, *R v Bain* [2004] 1 NZLR 638 (CA) at [22]–[27]; approved in *Bain v R* [2007] UKPC 33, (2007] 23 CRNZ 71 at [103].

119 The initial grounds of appeal included that the Judge failed to take into account that Dr Webb said "J should be considered to have intellectual disabilities" not that he was intellectually disabled. This ground was not advanced in the submissions.

assessment made for the District Court in 2005, some 11 years previously.[120]

[182] The definition of intellectual disability is contained in s 7 of the IDCCR Act, which is set out above.[121] In the context of determining whether a person has an intellectual disability, it is critical to examine the s 7 indicia. It includes both sub-average general intelligence **and** significant deficits in adaptive functioning skills. I have been referred to the select committee stage of the Intellectual Disability (Compulsory Care) Bill, where Dr Lynda Scott explained the reason the Health Select Committee had considered the inclusion of both indicia. She said:[122]

> It was essential that we manage to have a definition with a broad enough scope to allow for the capture of people who have a low IQ, around 70, and who may have some skills in some areas but very poor skills in others, which leads to their offending. If they do have very poor social skills, or have been trained in inappropriate behaviour, then they need to be captured by this bill so that they can go into a care programme to improve their behaviour and to protect themselves and the public. The meaning of "intellectual disability" was expanded to allow this to happen …

[183] Thus, the test for intellectual disability in s 7(1) is determined:

(a) if the person has a permanent impairment that "results in significantly sub-average general intelligence";

(b) the person has "significant deficits in adaptive functioning as measured by tests generally used by clinicians, in at least two of the skills listed in subsection (4)"; or

(c) the intellectual disability must become apparent during the developmental period of the person.[123]

[184] Of relevance here, s 7(2) of the IDCCR Act provides:

> Where ever practicable, a person's general intelligence must be assessed by applying standard psychometric tests generally used by clinicians.

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120 *Harvey v Makitae* [2016] NZFC 10178.
121 At [163] of this judgment.
122 (21 October 2003) 612 NZPD 9583.
123 Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 7(1)(c).

[185] The Care Coordinator submits that this section enables a finding of sub-average general intelligence in cases where it has not been practicable to conduct psychometric testing. In the Care Coordinator's submission, reference is made to the Parliamentary changes to the Bill and the Supplementary Order Paper, where the definition of intellectual disability was changed to limit the requirement to apply psychometric tests, to cases where it is practicable.[124]

[186] Further, under s 7(3), an assessment of a person's general intelligence under s 7(1)(a) "is indicative of significantly sub-average general intelligence if it results in an intelligence quotient that is expressed as 70 or less and with a confidence level of no less than 95%." The Care Coordinator submits, and I accept, that the statutory language reinforces Parliament's concern in that the scope of the definition of intellectual disability should not be unduly narrowed to rely solely on the results of psychometric testing.

[187] Having addressed ss 3, 7, 11 and 85 of the IDCCR Act, referred to *RIDCA*[125] and two decisions of the Manukau Family Court,[126] the Judge considered the issue of whether J has an intellectual disability as defined by s 7 of the IDCCR Act. The Judge had three health assessors' reports including Ms Breen's and heard the evidence of two of the health assessors, Dr Thomson and Ms Jensen, Dr Webb and the Care Coordinator, Mr Harvey.

Ms Breen's report

[188] After undertaking a cognitive assessment of J in 2005, using the Wechsler Adult Intelligence Scale, in which Ms Breen concluded that J's full-scale IQ (FSIQ) was in the range of 58–68. Ms Breen noted J's poor verbal comprehension, working memory and processing speed, in contrast to his average perceptual organisation abilities. J was assessed as functioning below 99.5 per cent of similar aged peers. J's adaptive behaviour was measured using the Vineland Adaptive Behaviour Scale and the results indicated significant deficit in J's ability to use skills required for everyday

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124 Supplementary Order Paper 2003 (160) Intellectual Disability (Compulsory Care and rehabilitation) Bill 2003 (329–2) (explanatory note) at 11.
125 *RIDCA*, above 64.
126 *Harvey v AT* [2016] NZFC 3928; and *Makitae*, above n 120.

living. His overall score put him below the first percentile with profound or severe deficits in communication, daily living skills and socialisation.

2016 specialist assessors' reports

[189] J was further assessed by two specialist assessors under ss 77(2)(c) and 78 of the IDCCR Act, prior to the Family Court hearing. The Judge referred to addendum reports of Dr Thomson and Ms Jensen both dated 13 November 2016, which addressed the jurisdictional issue of J's ongoing intellectual disability. Both reports addressed J's assessment in 2005 by Ms Breen and concluded, after assessing J, that Ms Breen's psychometric testing and assessment was still valid. J's intellectual disability is considered to be life-long and permanent.

[190] In the addendum to his report, dated 13 November 2016, Dr Thomson stated:

> [J's] impairments are considered to be lifelong, pervasive limitations on his intellectual functioning and ability to acquire adaptive skills. Also, [J] has been previously found unfit to stand trial due to mental impairment (intellectual disability), he is reliant on his support staff to help with daily routines and his presentation is consistent with someone with an intellectual disability and autism spectrum disorder.

[191] Dr Thomson also gave evidence in the Family Court that in his opinion, J's intellectual disability is a life-long condition, that there is little prospect of his transcending. J would continue to meet the criteria for intellectual disability as measured by a standardised test of intelligence and J needs a high level of support to achieve the daily requirements of his life, which Dr Thomson specifically stated "is the other important aspect of a diagnosis of intellectual disability".

[192] Ms Jensen in the addendum to her report echoed the same conclusions. She stated:

> It is my opinion that [J's] 2005 assessment is still valid. There is no evidence to suggest there has been a substantial improvement in [J's] functioning since this assessment. In my opinion his intellectual disability is a permanent impairment. This has also been the opinion of previous specialist assessors.

[193] In addition, Dr Webb was engaged on behalf of J, to assess his intellectual functioning and provide an opinion about his current living situation. Dr Webb assessed J using a number of tests:

(a) Using the Wechsler Adult Intelligence Test WAIS-IV (WAIS) she concluded that J's perceptual reasoning index was in the low-average range. His matrix reasoning sub-test score was on the fifth percentile, but his block design sub-test (copying visual patterns) was on the fiftieth percentile, in the average range. His verbal comprehension index was extremely low at the 0.2 percentile; his working memory index was at 0.1 percentile and extremely low. The speed with which J solved problems (his processing speed index) was extremely low in the 0.3 percentile. The pattern of scores aggregated to produce a FSIQ of 60 in the extremely low range. His general ability index was 70, also in the extremely low range.

(b) Using the Peabody Picture Vocabulary Test, J scored on the second percentile and his ability to recognise the meaning of words as presented to him pictorially was in the extremely low range.

(c) Using the Raven's Progressive Matrices, which involves solving problems with just visual material and does not involve language, J scored in the fourteenth percentile on the matrices, with an estimated IQ of about 84.

[194] Dr Webb's report, dated 13 November 2006, concluded as follows:

> [J] has an unusual pattern of cognitive abilities. Whilst he has average visual problem-solving skills, his other cognitive functions are extremely low.
>
> Specifically, his verbal understanding and general knowledge are Extremely Low and [J's] Working Memory Index score suggests that he has very little ability to use knowledge and skills that he might accrue in the course of his daily activities to make daily decisions and solve problems.
>
> He should be considered to have intellectual disabilities and so eligible for support under the terms of the IDCC&R Act.

[195] When she gave evidence in the Family Court, Dr Webb confirmed her opinion that J should be considered to have intellectual disabilities and so eligible for support under the IDCCR Act. In re-examination, Dr Webb explained how she made a finding of intellectual disability, despite the variance in the scores obtained for the Raven's Progressive Matrices Test and the WAIS-IV Test. Dr Webb said:

> As far as the tests are concerned, usually when people sit the WASI-type IQ tests, the test is made up of 10 or 11 sub-tests and usually if I have … an average IQ, I will have average perceptual skills, average verbal skills, average prompt … People with autism have – and other people with different syndromes – sometimes you get that distribution of scores skewed and so we have all of these perceptual sub-tests and all of the verbal sub-tests. Now, the Raven's correlates with part of the WASI and … it seems very high compared to the overall. It's because the … abilities are skewed and it correlates only with that part of the WASI because he scored … I think fiftieth percentile on one sub-test … in the WASI but these scores are right down so this means he can't understand what people are saying to him, he can't solve problems, he can't learn from his experiences in the usual way and so that makes him intellectually disabled.

[196] The Judge noted that the specialist assessors, Dr Thomson and Ms Jensen, did not assess J's IQ but the 2005 intellectual disability test was administered by a qualified psychologist and the evidence presented on behalf of J by Dr Webb, supported the conclusions of both Dr Thomson and Ms Jensen that J's intellectual disability satisfied the jurisdictional test in s 7 of the IDCCR Act.[127]

[197] Dr Ellis challenges the Judge's reliance on an IQ assessment prepared for the District Court in 2005, some 11 years previously by Ms Breen. Dr Ellis also challenges the assessments by the specialist assessors, Dr Thomson and Ms Jensen, as not being of the standard suggested in *Makitae*, namely, that repeated psychometric testing is not always necessary, but if not undertaken, the assessors should record why not.[128]

Conclusion

[198] There are four reasons why I reject the appellant's submission:

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127 *Goodwin decision*, above n 95, at [64].
128 *Makitae*, above n 120.

(a) The Judge specifically addressed the two decisions of the Manukau Family Court, including *Makitae*, and took from those decisions the most pertinent finding, that the criteria for the assessment of whether a care recipient continues to suffer from an intellectual disability is a combination of clinical tests and clinical observations. A clinician's determination does not have to include psychometric testing.[129]

(b) The specialist assessors review reports were filed before the decision in *Makitae* was released and following its release, the assessors provided their addendum reports dated 13 November 2016, to which the Judge specifically referred. Those reports, as set out above, stated why further psychometric testing was not considered necessary or appropriate. The fact that Ms Breen undertook J's assessment in 2005 does not mean that it is invalid.

(c) The *AT* and *Makitae* decisions reinforce the importance of clinical reports, filed for the purposes of a court review hearing, addressing all the criteria in s 7 of the IDCCR Act. In particular, *Makitae* affirms that it is often not necessary to administer repeated psychometric tests as part of the review, but if psychometric testing is not undertaken, to record why that decision was made.[130] This was done by the two specialist assessors in their addendum reports. The standard in *Makitae* was followed faithfully.

(d) Dr Ellis' submission overlooks the fact that, as the specialist assessors record, J's intellectual disability is a permanent impairment. The 2005 assessment was still valid. In the definition of "intellectual disability" under s 7 of the IDCCR Act, a person has an intellectual disability, if the person has a **permanent impairment**. It is therefore unsurprising, that although the specialist assessors checked for evidence of any substantial improvement in J's functioning since the 2005 assessment, there was no substantive change.

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129 *Goodwin decision*, above n 95, at [60(b)].
130 *Makitae*, above n 120, at [25].

[199] It was appropriate for the Judge to have regard to and rely on the specialist assessment reports and evidence, to establish and confirm that J is intellectually disabled. This ground of appeal is dismissed.

(b) Did the Judge apply the wrong legal test and standard of proof to the extension of the care order under s 85?

[200] J submits that the Judge erred in law in applying the legal test for an extension of a care recipient order under s 85. The Judge concluded the appropriate standard was the civil standard, on the balance of probabilities, and gave six reasons for doing so:[131]

(a) The wording in s 6(3)(b) of the IDCCR Act, which defines a "care recipient no longer subject to the criminal justice system" as a person who "is subject to an order made under s 25(1)(b) or s 34(1)(b)(ii) of the CPMIP Act", makes clear that a person in J's position is no longer subject to the criminal justice system.

(b) The IDCCR Act is complementary to the MHCAT Act, which has been recognised as not involving the criminal justice system.[132]

(c) Compulsory care orders are dealt with in the Family Court where the standard of proof is the civil standard of balance of probabilities.

(d) The proceedings are protective rather than punitive in nature. They focus on protecting the community and providing appropriate care and rehabilitation, as reflected in s 3 of the IDCCR Act.

(e) Even if compulsory care orders were determined as criminal proceedings, this does not mean that the standard of beyond reasonable doubt applies.[133]

(f) The test applied to compulsory care orders is a balancing exercise between the interests of the community and the relevant individual.

[201] J submits the Judge erred in the following ways:

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131 *Godwin decision*, above n 95, at [20].
132 *Belcher v Chief Executive of the Department of Corrections* [2007] 1 NZLR 507 at [37].
133 *McDonnell v Chief Executive of the Department of Corrections* [2009] NZCA 352, (2009) 8 HRNZ 770 at [71]–[75].

(a) failing to fully consider the case of *Koon Wing Yee v Insider Trading Tribunal*;[134]

(b) failing to have regard to a third category of cases, identified in *Belcher*, where the legislation provides for restrictions on those who are at high risk of future criminal, dangerous or otherwise antisocial behaviour, and there may be a risk of double jeopardy;[135]

(c) considering that the civil standard of proof applies;

(d) finding the proceedings are not punitive;

(e) relying on *McDonnell v Chief Executive of the Department of Corrections*;[136] and

(f) applying the test in *RIDCA* incorrectly.[137]

Discussion

[202] The starting point for this analysis is s 85(5) of the IDCCR Act, which does not prescribe the criteria by which an application for an extension of a compulsory care order should be determined. Section 88 requires the Court to "have regard to" the most recent certificate given by a specialist assessor under s 79 and the Court may obtain a second opinion from another specialist assessor.

[203] However, before making an order under s 25(1)(b) of the CPMIP Act, that a person unfit to stand trial be cared for as a care recipient under the IDCCR Act, the Court must be satisfied on the evidence of one or more health assessors that the defendant:[138]

(a) has an intellectual disability; and

(b) has been assessed under Part three of the IDCCR Act; and

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134 *Koon Wing Yee v Insider Trading Tribunal* [2008] HKCFA 21, [2008] 3 HKLARD 372.
135 *Belcher*, above n 132, at [37].
136 *McDonnell*, above n 133.
137 *RIDCA*, above n 64.
138 Criminal Procedure (Mentally Impaired Persons) Act 2003, s 25(3).

(c) is to receive care under a care programme completed under s 26 of the IDCCR Act.

[204] The same language is found in s 45(1) of the IDCCR Act, where a care coordinator makes an application for a compulsory care order. In *RIDCA* the Court of Appeal held that a Judge determining an extension application must be "satisfied" that the community protection interest cannot be met other than by a compulsory care order.[139] Notably, the Court in *RIDCA* did not hold that the criminal standard of proof applies in compulsory care order extension applications. The Court in *RIDCA*, as did the Family Court Judge, proceeded on the basis that a person found unfit to stand trial has been removed from the criminal justice system, consistent with s 6(3)(b) of the IDCCR Act. This occurs, despite the fact that the power to make a compulsory care order arises on the commission of an offence and the initial process is governed by the CPMIP Act, which is criminal justice legislation.

[205] I accept the Care Coordinator's submission, that dispositions of proceedings under s 25(1)(b) of the CPMIP Act do not apply as alternatives to the imposition of a criminal sentence, but are available only where a person has been specifically removed from the criminal justice system, after being found to be unfit to stand trial. That is consistent with s 6(3)(b) of the IDCCR Act.

[206] The civil standard of proof applies also in proceedings to determine a defendant's involvement in an offence under s 9 of the CPMIP Act. The Court of Appeal in *Ruka*, specifically referred to the Select Committee's report on the Criminal Justice Amendment Bill, in which the report's authors considered that the appropriate standard of proof, following a finding of unfitness, is on the balance of probabilities.[140] The report urges that a finding of unfitness does not involve a determination of criminal liability. It is civil detention, not criminal detention, which is the outcome. The Court of Appeal agreed.

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139 *RIDCA*, above n 64, at [92(a)].

140 *Ruka*, above n 93, at [82], citing Criminal Justice Amendment Bill (No 7) 1999 (328-2) (select committee report) at 4–5.

[207] Collins J in his 2017 decision also held that the standard of proof for unfitness to stand trial was the civil standard and it was logical for the same standard to apply for an application for extension under s 85 of the IDCCR Act.[141] I concur, and, with respect, have no reason to depart from *Ruka* or Collins J's decision.

[208] Further, I am unable to uphold J's submissions that Judge Goodwin erred in his reference to *Belcher* and his failure to find that the IDCCR Act falls into the third category identified in *Belcher*, namely, those cases where there is high risk of future dangerous behaviour and any sanctions may pose a risk of double jeopardy.[142]

[209] I consider the Judge was correct to refer to the IDCCR Act as being complementary legislation to the MHCAT Act, applying however, only to persons with intellectual disabilities. The Court in *Belcher* specifically noted the MHCAT's powers "plainly have nothing to do with the criminal justice system".[143] The options under s 25 of the CPMIP Act, being either MHCAT or IDCCR dispositions, reinforce the complementary powers in each of the Acts. There can be no distinction between care recipients placed under s 25(1)(b) of the CPMIP Act, namely a care recipient under the IDCCR Act and those placed under s 25(1)(a) compulsory treatment orders through the MHCAT Act. Neither remain subject to the criminal justice system, as s 6(3)(b) of the IDCCR Act makes clear. I accept the Care Coordinator's submission that such a distinction would be nonsensical.

[210] J's submission that the Judge erred in relying on *McDonnell* is also not upheld.[144] In *McDonnell*, the Court was considering the extended supervision order legislation, which requires a Judge to be "satisfied" that an order should be imposed.[145] The IDCCR Act does not use that word. The Judge referred to *McDonnell* to reinforce that even if compulsory care orders were determined as being criminal proceedings (which they are not), this does not mean that the criminal standard of proof beyond

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141 *J*, above n 3, at [82]–[85].
142 *Belcher*, above n 132, at [37]–[38].
143 At [37].
144 *McDonnell*, above n 133.
145 Parole Act 2002, s 107I(2).

reasonable doubt applies.[146] The Court of Appeal in *McDonnell* specifically addressed the meaning of "satisfied". The Court said:[147]

> The need to be "satisfied" calls for the exercise of judgment by the sentencing Court. It is inapt to import notions of the burden of proof and of setting a particular standard, eg beyond reasonable doubt. … The phrase 'is satisfied' means simply 'makes up its mind' and is indicative of a state where the Court on the evidence comes to a judicial decision. There is no need or justification for adding any adverbial qualification …

[211] It should be noted that in *McDonnell*, the Court was dealing with extended supervision orders in the criminal setting and the Court accepted that they are a penalty. However, even though they are within the criminal justice setting, the Court held it did not require the criminal standard of proof beyond reasonable doubt to be applied to extension of supervision orders.[148] There was no error by the Judge in relying on *McDonnell* for support that the criminal standard of proof does not apply.

[212] I am also unable to uphold J's submission that Judge Goodwin failed to fully consider the decision of the Hong Kong Court of Final Appeal in *Koon Wing Yee* and failed to find imposing a compulsory care order would be punitive.[149] I accept the Care Coordinator's submission that this decision can be distinguished. In *Koon Wing Yee*, the Court held that proceedings in the Hong Kong Insider Dealing Tribunal, in relation to allegations of insider trading, were criminal proceedings which involved the determination of a criminal charge by reason of the power to impose a "penalty".[150] In determining this, the Court considered that the proceedings involved an allegation of serious misconduct, the legislation governing insider trading provided for dual civil and criminal regimes, as well as the fact that the penalty imposed was comparable to a fine with a punitive purpose (as opposed to a protective purpose).[151]

[213] The circumstances of *Koon Wing Yee* differ markedly from J's case. Compulsory care orders do not have a punitive purpose. The focus of such orders is on protecting the community and providing appropriate care and rehabilitation for the

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146 *Goodwin decision*, above n 95, at [20(e)].
147 *McDonnall*, above n 133, at [72], citing *R v Leitch* [1998] 1 NZLR 420 (CA) at 428.
148 *McDonnell*, above n 133, at [75].
149 *Koon Wing Yee*, above n 116.
150 At [66].
151 At [46]–[49].

care recipient, as evidenced by the purposes of the IDCCR Act.[152] For the reasons already discussed,[153] applications to extend compulsory care orders are not criminal proceedings.

[214] The issue of whether a court is satisfied a compulsory care order should be extended under s 85(1) of the IDCCR Act must be determined on the civil standard of the balance of probabilities. Judge Goodwin did not err in applying this test. This ground of appeal also fails.

(c) Did the Judge overlook J's arbitrary detention contrary to s 22 NZBORA?

[215] J submits that the Judge failed to find that J's liberty interest meant his release was required, as his continued detention was an arbitrary detention contrary to s 22 of the NZBORA. This, J submits, meant the Judge failed to consider secure care as a last resort.

[216] In the CPMIP appeal and judicial review claim (Parts 1 and 4 of this judgment respectively), J also pleads his detention is arbitrary detention. I will deal with this claim more fully in Part 4 of this judgment.[154]

[217] For the purposes of the Family Court appeal, however, I cannot uphold J's submission. Judge Goodwin expressly considered J's liberty interest in depth in his judgment, despite not directly referring to s 22 of the NZBORA.[155] The Judge explicitly considered that he was "more than aware of the effects of [his] decision on [J's] liberty interest" and J must be protected from arbitrary detention.[156] The Judge identified that the length of time J had already been under a compulsory care order (over ten years at that time), the relative seriousness of the index offences, and the concerns about J's care and rehabilitation at Solway Vision expressed by the health assessors, were "most troubling for the Court."[157] However, the Judge determined that J's liberty interest must, in this case, be balanced against his risk, the need for

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152 Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, ss 3 and 11.
153 At [198]–[200] of this judgment.
154 At [438]–[505] of this judgment.
155 *Goodwin decision*, above n 95, at [85]–[109].
156 At [101].
157 At [85].

community protection and the compelling reasons to extend his compulsory care order identified by the various health assessors.

[218] In addition, the Judge addressed the possibility of detaining J under a voluntary civil order in the type of care available at Solway Vision.[158] However, J could not attend this facility if he remained subject to a compulsory care order and, given the evidence of J's risk to others and himself, an extension of J's order and a variation to secure care, was appropriate. I reject J's submissions that the Judge erred in law in these matters.

[219] Dr Ellis submits the Judge's finding to vary J's compulsory care order from supervised to secure care was flawed. Under ss 85(3) and 86(4) of the IDCCR Act, the Court may order that a care recipient receive secure care "only if it considers that supervised care would post a serious danger to the health or safety of the care recipient or of others." The evidence of both specialist assessors before Judge Goodwin supported the variation of J's compulsory care order to secure care because of his risk identified in their assessments. The assessors were called and cross-examined. It was open to the Judge to make the variation, as it was supported by compelling evidence. This is dealt with further under Part 3 of this judgment.[159]

[220] The Judge did not fail to consider secure care as a last resort: he was alive to the concerns about J's liberty interest as well as the risk of arbitrary detention and sought to balance these in his decision to extend and vary J's compulsory care order. J's submission that the Judge overlooked the risk of arbitrary detention cannot be upheld. This ground of appeal fails.

(d) Did the Judge err in concluding the maximum term of detention was not cumulatively three years?

[221] J submits that compulsory care orders cannot be extended beyond a three year period. Section 46 of the IDCCR Act provides:

> **46 Term of compulsory care order**
>
> (1) Every compulsory care order lasts for the term specified in the order.

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158 At [90]–[100].
159 At [413]–[428] of this judgment.

(2) The term specified under subsection (1) may not be longer than 3 years.

(3) The term specified in the order may be extended under section 85.

[222] On a plain reading of s 46, an initial compulsory care order may be made for a term not longer than three years. However, this term may be extended under s 85. Collins J, in the judicial review proceedings in this matter, was satisfied that the plain meaning of the tests of ss 46 and 85 of the IDCCR Act, is that there is not a three year total limit to the term of a compulsory care order.[160] Collins J agreed with Mallon J's interpretation in *L v RIDCA*, where her Honour stated:[161]

> [12] A compulsory care order must specify its term. That term cannot be longer than 3 years, but there is provision for extension of the order. It seems to be accepted that if an extension is granted then that can be done indefinitely, that is with the effect that the compulsory care could extend for a total period well in excess of three years, provided the Court is satisfied that the extension should be made. In theory at least, that makes the extension power capable of having preventive detention effect.

[223] The Judges' interpretation of these sections is supported by the Court of Appeal in *RIDCA*, where the Court acknowledged that a compulsory care order may be extended under s 85, resulting in a total term of the order exceeding three years. The Court of Appeal said:[162]

> [90] As already noted, s 11 of the IDCCR Act does not apply to the making of a compulsory care order in the circumstances applying to VM. So the argument founders on that basis alone. But even if that factor is put to one side, we do not accept the argument as correct in principle. The argument depends on not only the risk being static, but also the liberty interest being static. We do not accept that the length of time for which a person has already been subject to a compulsory care order can be ignored when assessing his or her liberty interest. This can be illustrated by a case where the assessment of the community protection interest against the care recipient's liberty interest was finely balanced at the first renewal of a compulsory care order. If, three years later, a further extension is sought and the community protection interest remains essentially the same, the balance against the extension may be tipped by the fact that the care recipient's liberty interest has become more compelling because he or she has already endured a significant period of reduced liberty. We do not see this as material other than in finely balanced cases. Where a care recipient constituted a significant danger to the public and compulsory care was necessary for community protection, the liberty interest of the care recipient, even if he or she had been in care for a long period, would not outweigh the community protection interest.

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160 *J*, above n 3, at [76].
161 *L v RIDCA* [2013] NZFLR 497(HC) at [12] (footnotes omitted).
162 *RIDCA*, above n 64, at [90] (footnote omitted).

[224] Collins J has already decided authoritatively on this issue in the judicial review proceedings and I concur with his view.[163] This issue should not be revisited in this appeal and this ground is dismissed.

(e) Did the Judge err in law in finding the specialist assessors' reports and J's drawing were admissible?

[225] J claims that the specialist assessors' reports and risk assessments were inadmissible, because the assessors were influenced by their faulty approach to risk. The reports were based on evidence obtained without consent or evidence that was protected. In particular:

(a) the report of Ms Jensen dated 24 September 2016 contains a drawing by J that was obtained by an unreasonable search and seizure;

(b) J was not advised of his rights and in particular his right to a lawyer at the time of being interviewed by Dr Thomson or Ms Jensen; and

(c) no consent was obtained from J or his welfare guardian to the use of prior assessors' psychiatric or psychological material, in particular, prior reports.

[226] The Family Court Judge recorded two grounds that were advanced against the admission of the reports:[164]

(a) a lack of explanation to J at the time of his being interviewed by both Dr Thomson and Ms Jensen for the reports, as to his rights, and in particular, his right to a lawyer; and

(b) no consent was obtained from J or his welfare guardian to the use of prior psychological material (in particular prior reports).

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163 *J*, above n 3, at [76].
164 *Goodwin decision*, above n 95, at [27].

[227] In dealing with this objection, the Judge referred to s 127 of the IDCCR Act, which provides:

> In a proceeding on an application under this Act, whether at first instance or on appeal or otherwise, the court may receive any evidence that it thinks fit, whether it is admissible in a court of law or not.

[228] There were six reasons advanced by the Care Coordinator why the reports and drawing were admissible. They are:

(a) Section 127 of the IDCCR Act is a complete answer to this ground of appeal.

(b) The specialist assessors were entitled to rely on previous specialist assessors' reports and reports from IDOLS.

(c) Ms Jensen explained to J in her interview that what was discussed was going to be contained in a report and that the report would be read by a number of people.

(d) J's drawing, referred to in the report of Ms Jensen, was as a result of J willingly providing the drawing. It was not obtained by way of an unlawful search or seizure.

(e) The interview process was not a new detention. Thus, there was no breach of J's right to consult a lawyer without delay and be informed of that right. On the contrary, the interviews were required to be conducted under s 77 of the IDCCR Act.

(f) Under s 88(1) of the IDCCR Act, the Court must have regard to the most recent specialist assessors' certificate.

[229] Specialist assessors, both clinically and by statute, must have regard to the previous clinical reviews or assessments undertaken on a care recipient. Section 88(1) mandates this requirement, as does good clinical practice. Further, s 77 of the IDCCR Act requires that every care recipient must be formally reviewed at the times specified

in s 77(2). As part of a specialist assessors' interview, care recipients (as with child complainants in other contexts), may be asked to express themselves by drawing or they may offer their drawings to the interviewer. The statutory provisions in the IDCCR Act, including s 127 on admissibility of evidence, overwhelmingly supports the admissibility of the reports and accompanying drawing. This ground of appeal fails.

(g) Did the Judge err in considering risk assessment trumps the rights of the care recipient?

[230] J submits Judge Goodwin failed to provide any reasons as to why the rights of the care recipient identified in s 11(b) of the IDCCR Act are trumped by the central question of risk assessment.

[231] In the Judge's decision, when considering the community protection interest, Judge Goodwin discussed the evidence before him relating to J's risk at length.[165] The Judge identified the key conclusions of the specialist assessors, including that J has a special interest in violence and he will impulsively act out his intent, his lack of understanding of the consequences of his actions and he continues to act violently while subject to close supervision and external controls. This led the Judge to conclude that he was "left in no doubt that [J] continues to pose a high risk of re-offending."[166]

[232] The Judge then balanced these considerations against J's rights as a care recipient, or his "liberty interest".[167] Although the Judge did not directly refer to s 11(b) of the IDCCR Act, by considering his liberty interest the Judge considered J's rights as a care recipient. The Judge identified that there was no question that J's liberty has been "severely eroded" by the length of time he has been in care and his rehabilitation has been compromised.[168] However, the Judge considered J's high risk, as evidenced by the specialist assessors, meant his compulsory care order must be extended. The Judge clearly balanced J's rights against the assessment of his risk, as

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165 *Goodwin decision*, above n 95, at [68]–[70] and [82]–[84].
166 At [84].
167 At [102]–[109].
168 At [103].

RIDCA mandates,[169] and determined that the community protection interest cannot be met in J's case other than by a compulsory care order.

[233] In light of this, I cannot accept J's submission that the Judge failed to provide reasons as to why J's rights as a care recipient were trumped by his risk assessment and the community protection interest. Indeed, the Judge gave a reasoned decision that was grounded in the requirements as set out in *RIDCA* and the specialist assessors' evidence of J's unique circumstances.

[234] I accept the Care Coordinator's submission that the Judge was correct to conclude that the risk posed by J trumped his liberty rights. The Judge gave a reasoned decision in reaching this conclusion. This ground of appeal fails.

(h) Did the Judge err in law in not cancelling the deferment order?

[235] Prior to Judge Goodwin's decision, J's previous compulsory care order was due to expire on 13 October 2016. The Care Coordinator made an application to defer the expiry of the compulsory care order, under s 87 of the IDCCR Act. On 3 October 2016, Judge Skellern ordered a deferral of the expiry of the compulsory care order until 13 December 2016. J's mother then filed an application to cancel Judge Skellern's deferment order.

[236] In his decision, Judge Goodwin rejected the application to cancel the deferment order. The Judge dealt with each of the challenges raised and concluded the following:[170]

(a) The challenge to the original order could not succeed as he did not consider he could revisit this on an application to cancel a deferment order.

(b) He rejected J's challenge on the basis of delay. If the extension to the care order is sought on the basis of a specialist assessor's report, it must reflect the condition of the care recipient at the appropriate time.

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169 *RIDCA*, above n 64, at [92].
170 *Goodwin decision*, above n 95, at [44]–[51].

(c) The challenge to the procedural defects in the warrant of detention of the deferment order was, at that time, before the High Court for judicial review. The Judge noted that a challenge to the order on the basis of arbitrary detention did not give rise to a cancellation of the order.

(d) J's challenge based on a breach of the NZBORA was also more appropriately dealt with in the judicial review proceedings before the High Court.

[237] The Judge declined to cancel the deferment order because cancellation would have had "drastic consequences", namely, J's release from compulsory care without any consideration of risk assessment or of the balance between the community protection interest and J's liberty interest.[171]

[238] J submits that the Judge erred in not cancelling the deferment order application and failed to engage with the NZBORA. J advances similar grounds as those raised before Judge Goodwin, namely that the extension order was invalid and thus incapable of deferment and the deferment order contained several deficiencies.

[239] I accept the Care Coordinator's submission that the Judge fully considered the application to cancel the deferral order, did not err in law and gave a reasoned decision as to why he declined the application. Given that cancellation would have resulted in the immediate release of J, without consideration of the statutory scheme, J's risk or care needs, such a result would have been contrary to the legislative scheme and inappropriate.

[240] This ground of appeal fails.

(i) Did the Judge err in not placing J at Solway Vision?

[241] J submits the Judge breached s 23(5) of the NZBORA and made an unreasonable decision when he failed to place J at Solway Vision, a mainstream intellectual disability service provider. Section 23(5) of the NZBORA specifies that

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171 *Goodwin decision*, above n 95, at [49].

everyone "deprived of liberty shall be treated with humanity and with respect for the inherent dignity of the person."

[242] The decision that J should be cared for at Te Roopu Taurima and not Solway Vision is a decision of the Care Coordinator under s 63 of the IDCCR Act. Section 63 provides:

> **63 Designation notices relating to secure care**
>
> (1) This section applies to every person—
>
> (a) who is a special care recipient; or
>
> (b) who is a care recipient no longer subject to the criminal justice system and who is required to receive secure care.
>
> (2) A care recipient to whom this section applies—
>
> (a) must stay in a secure facility that the co-ordinator designates by written notice given to the care recipient and the care recipient's care manager; and
>
> (b) may not leave the facility without authority given under this Act.

[243] In determining an application for an extension of a compulsory care order under s 85, the Family Court must decide whether to extend the order and whether the order is for supervised or secure care. It is then the role of the Care Coordinator to determine where the care recipient will reside. I accept the Care Coordinator's submission, that the decision regarding J's residence does not form part of Judge Goodwin's decision under appeal in these proceedings, as the Family Court did not have jurisdiction to make this order.

[244] The Judge's discussion about the possibility of J residing at Solway Vision must be seen in this context. Indeed, the Judge recognised that so long as J remains subject to a compulsory care order, he cannot be placed at Solway Vision because it is a voluntary care facility. The Judge concluded that placement at Solway Vision "cannot be achieved under the statutory framework in which this decision is being considered."[172]

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172 *Goodwin decision*, above n 95, at [99].

[245] There has been no breach of s 23(5) NZBORA, nor has the Judge erred.

[246] This ground of appeal is dismissed.

(j) Did the Judge err in his interpretation of RIDCA v VM?[173]

[247] J submits Judge Goodwin's interpretation of *RIDCA* was wrong as he refers to J's "offending", a "high risk of reoffending" and that J's "original offending" was minor and does not provide an accurate guide to his risk. It is argued that J's detention, based on his risk and intellectual disability, is discriminatory and an arbitrary detention.

[248] In *RIDCA*, the Court held that the principles in s 11 of the IDCCR Act require a balancing exercise between the interest of the community in protecting the health and safety of the care recipient and others (the community protection interest) and the individual liberty interest of the care recipient.[174] This is the guiding principle to be applied in extension decisions. Where the community protection interest cannot be met other than by a compulsory care order, the Court held the order can be extended.[175]

[249] In assessing this balancing exercise, the Court of Appeal held that the nature of the original offending is relevant to an extension decision where it provides the Judge with an indicator of the level of risk posed by the care recipient.[176] This can be taken into account with the clinical assessments of the health assessor in determining the weight to be given to the community protection interest. The Court also identified that there may be situations where a care recipient "committed a minor offence but constitutes a very significant and ongoing risk to the public".[177] In such a case, the Court stated:[178]

> the community protection interest will overwhelm the liberty interest, and the assumption must be that the minor nature of the offending did not provide an accurate guide to the level of risk posed by the care recipient. Thus we do not consider it is likely that a dangerous person could be released because the nature of the offending was taken into account in the risk assessment.

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173 *RIDCA*, above n 64.
174 At [31]–[36].
175 At [92(a)].
176 At [92(d)].
177 At [94].
178 At [94].

[250] In an ironic twist, Dr Ellis submits that the Judge failed to respect J's rights under s 11 of the Act, by saying that J posed a "high risk of reoffending," when J has never offended but has been diverted into the CPMIP Act system. It is ironic, as J's CPMIP appeal and the Family Court appeal is a challenge (in part) to the finding that J was unfit to stand trial and was therefore deprived of fair trial rights and was arbitrarily detained. However, in a reversal of position, Dr Ellis submits that the Judge breached J's rights to the s 25(c) NZBORA presumption of innocence by referring to J's **offending** or **reoffending**.

Discussion

[251] It is correct that J has not "offended" in the sense, that he has been charged with criminal offences but has not been convicted, because he was diverted through the CPMIP system into IDCCR Act care and thereby was no longer subject to the criminal justice system.[179] These were facts plainly before the Judge in his review of J's compulsory care order. It appears to me that when the Judge referred to the nature of J's "original offending" and his "high risk of offending if released today",[180] he was making specific reference to the specialist assessors' conclusions on J's risk.

[252] Ms Jensen referred to J's "risk of reoffending" being rated in the high range with ongoing concerns about how J's risk could be managed. Similarly, Dr Thomson confirmed that J remains at a "high risk of further violent offending". From the context in which the Judge was delivering his decision, it is self-evident that he was referring to the specialist assessors' terminology and using that terminology to discuss the ongoing level of risk J poses in relation to the community.[181]

[253] The same terminology of risk of offending is used by the Court of Appeal in *RIDCA* where the Court, in setting out the guiding principles in relation to compulsory care order extension decisions, referred to a care recipient "who committed a minor offence" but who constitutes a very significant and ongoing risk to the public.[182] The Court gives a specific example:[183]

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179 Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 6(3).
180 *Goodwin decision*, above n 95, at [108].
181 At [108].
182 *RIDCA*, above n 64, at [94].
183 At [94].

> … for example, a care recipient who is at high risk of offending sexually against children, but who was apprehended only for a minor offence.

[254] It is clear that the Court of Appeal, the specialist assessors and the Judge have all referred to the "original offending", "high risk of offending" or "reoffending" to refer to a care recipient's behaviour, which, but for the care recipient's disability, would result in criminal charges.

[255] The Judge concluded that J's case is one where J's "original minor nature of offending did not provide an accurate guide to the level or risk that he poses" to the public, just as was contemplated by the Court of Appeal.[184] In support of this conclusion, the Judge thoroughly examined the evidence of the specialist assessors to assess the unique risk J poses. The Judge interpreted and applied the conclusions correctly, specifically referring to the findings of the Court of Appeal in *RIDCA* outlined above.[185] J's case is not a borderline case, as the evidence from the specialist assessors clearly establishes the risk J poses to the community.

[256] Far from breaching J's rights to the presumption of innocence contained in s 25(c) of the NZBORA, the Judge assessed J's risk within the "diverted" protective system of the IDCCR Act, where J cannot be convicted for "offending", but must be assessed for risk. I reject J's submission in this regard.

[257] Although J challenges the use of risk assessment tools in determining detention for care recipients,[186] I find that the Judge correctly applied the decision in *RIDCA*.

[258] J's submissions that his detention is discriminatory and an arbitrary detention will be addressed in detail in Part 4 of this judgment.[187] For the purposes of this Family Court appeal, however, I find that the Judge correctly interpreted and applied the *RIDCA* guidelines to the extension of J's compulsory care order, in accordance with the statutory scheme. J's detention was lawful and not arbitrary. This ground of appeal fails.

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184 *Goodwin decision*, above n 95, at [108].
185 At [105]–[107].
186 Relying on Susan Glazebrook "Risky Business: Predicting Recidivism" (2010) 17(1) *Psychiatry, Psychology and Law* 88; and Human Rights Committee *Views: Communication No 1629-2007* XCVIII CCPR/C/98/D/1629/2007 (18 March 2010) (*Fardon v Australia*) at [7.4.4].
187 At [438]–[572] of this judgment.

(k) Was the decision to extend J's compulsory care order by 18 months unreasoned?

[259] J submits the Judge's decision to extend J's order by 18 months, rather than any other number, was not properly reasoned. Mr Ellis submits that the 18 month extension extends the length of the order to 12 years and the lack of reasoned explanation as to why 18 months was chosen is both unreasonable and insufficient.

[260] The Judge expressed his concern that imposing a three year order would take J's total period of detention to 13 and a half years. The Judge recorded that there was "some common acceptance" that J's rehabilitation has been less than optimum.[188] In an acknowledgement of Dr Webb's evidence, the Judge was open to whether a rehabilitation programme, such as suggested by Dr Webb, might result in some rehabilitative progress for J.

[261] The Judge acknowledged that the review process is stressful to J and that stress is one of the triggers for J's risk behaviour, but this did not outweigh the necessity of ensuring an ongoing review process for J. For that reason, the Judge considered 18 months was more appropriate than three years, because J's current situation and lack of rehabilitative progress on the basis of failures to impose a rehabilitative plan meant that the order should be less than three years. The Judge appropriately undertook the balancing exercise required by *RIDCA* and gave reasons for doing so.[189] This ground of appeal is also dismissed.

Further observations

[262] In making the extension order for a period of 18 months, the Judge expressed his concerns about imposing an order for three years, given J's detention period, which, at the time of the Judge's decision, was ten and a half years. The Judge had listened carefully to the evidence from J's welfare guardian and the witnesses called on her behalf, that J's rehabilitation plan and programme had been less than ideal. The Judge specifically held open the option for rehabilitation progress for J, once a rehabilitation programme was put in place.

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188 *Goodwin decision*, above n 95.
189 *RIDCA*, above n 64.

[263] In his judgment, as part of his closing observations, the Judge noted the significant gap between the type of model of care delivery and rehabilitation as proposed by Dr Webb and that which had been delivered.

[264] Under s 75 of the IDCCR Act, the Court directed the District Inspector, Ms Fuata'i to file a report, which she completed, by way of memorandum dated 9 February 2017. In her report, Ms Fuata'i raised a number of matters in relation to J's care in the previous months. These included that documentation of incidents and observations by the staff needed improvement in terms of accuracy, consistency and timeliness, with completions of incident forms, because unreported incidents were an underestimation of the ongoing risks that J presented to himself and others. There was a concern that the incident reports alone were not conveying an accurate picture of J's reported risks.

[265] Further, concerns had been raised with the Care Manager that there was a need for an "autistic specific plan" for J, because J was having outings cancelled as a consequence of behavioural incidents, leading to an increased feeling of isolation for J. The District Inspector, as part of her role, raised the issue with the agencies involved in J's care: whether one person could be designated the lead care person for J, so that there were no gaps or impasses in the delivery of care by the various agencies to J.

[266] The Judge referred specifically to the District Inspector's memorandum, where she reported that in J's case, with the multiple teams/agencies involved, there would be far more effective and coordinated care for J, if there was a specified lead/agency or coordinator. The Judge took the opportunity to endorse those concerns and recommendations.

[267] At the same time, the Judge noted, that in the absence of the restrictions currently operated by J's care team, there is a serious danger to his care team and quite possibly to J himself. This concern was echoed by the District Inspector. While she acknowledged J's mother's concern that J was deteriorating in care because of his increased containment, Ms Fuata'i submits that those concerns do not address J's complex presentation and intellectual disability.

[268] There is, as in all assessment of risk, a balancing of the two interests: the community and J's liberty interests. In my view, the Judge was urging that a rehabilitation programme which may provide some progress for J, was a matter to be reviewed, following its implementation. This reinforces my view, that the Judge appropriately applied the guiding principles in *RIDCA*; did not merely rubber-stamp the specialist assessors' reports; and carefully weighed the evidence called on behalf of J with the specialist assessors' evidence, to ensure that the restrictions currently in operation continue, to avoid further potential risk behaviour or serious danger to J or to others.

Conclusion

[269] The Judge did not err in interpreting and applying the law or in assessing the evidence of the specialist assessors. My decision (on an *Austin Nichols* approach) would not differ from that of the Judge.[190] The Judge carefully considered the evidence before him, as well as J's particular circumstances, and correctly assessed that J's compulsory care order should be extended and varied. The Judge was alive to the issues with J's ongoing care, checked with the liaison District Inspector and took those matters into account in his assessment.

[270] The Family Court appeal is dismissed.

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[190] *Austin Nichols*, above n 97.

PART 3 – HIGH COURT INQUIRY UNDER SECTION 102 IDCCR ACT

[271] J, by his welfare guardian, has filed an application seeking:

(a) an order under s 102(2) of the IDCCR Act directing the care manager to bring J before the High Court for examination; and

(b) an order under s 104 of the IDCCR Act that J cease to be a care recipient.

[272] It appears that this is the first application to be filed under s 102 of the IDCCR Act, which empowers a High Court Judge to conduct an inquiry into the lawful detention of a care recipient and whether care should continue.

Relevant facts

[273] The initial compulsory care order for J was made on 8 February 2006, after J had been found unfit to stand trial in relation to the two criminal charges, the details of which have been canvassed under Part 1 of this decision.[191] Prior to this hearing, there have been eight extensions to the terms of the compulsory care order made under s 85 of the IDCCR Act and eight deferrals of the expiration of compulsory care orders made under s 87 of that Act.[192]

[274] On 29 September 2016, the Care Coordinator applied to extend the compulsory care order and to vary the order for secure care, as opposed to supervised care. The Care Coordinator also made a without notice application to defer the expiry of the compulsory care order under s 87 of the IDCCR Act, which was granted by Judge Skellern on 3 October 2016.

[275] J's mother and welfare guardian opposed the extension of the compulsory care order and applied to cancel the deferral order.

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191 At [39] of this judgment.

192 The details of the eight extensions and eight deferrals are set out in *J*, above n 3, at [20]–[43].

[276] On 27 February 2017, Judge Goodwin in the Family Court declined to cancel the deferral order and granted the application to extend the compulsory care order by a period of 18 months. He also granted the application to vary the compulsory care order, so the order was for secure care. J, through his welfare guardian, has unsuccessfully appealed that decision and the appeal is canvassed in Part 2 of this decision.

The application

[277] On this application, J contends he is detained unlawfully as a care recipient because he does not have an intellectual disability. J also says that even if he has an intellectual disability, he no longer needs to be cared for as a care recipient. J relies on the inquiry sections of the IDCCR Act to enable a more in-depth assessment by the Court of the basis for his detention.

The legislative procedure

[278] Sections 102 and 103 of the IDCCR Act set out the process for a High Court Judge's inquiry into the legality of a detention of a person held in compulsory care. If the Judge is satisfied that the person is illegally detained or no longer needs to be cared for as a care recipient, s 104 empowers the Judge to order the person's release.

[279] The process for a Judge conducting the inquiry and determining whether to exercise the s 104 power and order the detainee's release is detailed in ss 102 and 103.

> **102 Judge may call for report on care recipient or summon care recipient**
>
> (1) A High Court Judge may make an order directing a district inspector or 1 or more other persons—
>
> (a) to visit and examine a care recipient who is detained in a facility; and
>
> (b) to inquire into and report on any matter relating to that care recipient that the Judge specifies.
>
> (2) Whether an order under subsection (1) has been made or not, a High Court Judge may make an order directing a care manager to bring a care recipient for whom the care manager is responsible before the Judge in open court or in Chambers, for examination at a time specified in the order.

(3) An order under subsection (1) or (2) may be made on the Judge's own initiative or on the application of any person.

103 Judge may summon witnesses

For the purposes of an examination of a person under section 102(2), the Judge may summon any specialist assessor or other witness to testify on oath in respect of any matter involved in the examination, and to produce any relevant documents.

[280] Section 104 provides the power for a Judge to release a care recipient, as follows:

104 Judge may release care recipient no longer subject to criminal justice system

After the examination, under section 102(2), of a care recipient no longer subject to the criminal justice system, the Judge may order that the care recipient cease to be a care recipient if the Judge is satisfied—

(a) that the care recipient is detained illegally as a care recipient; or

(b) that the care recipient no longer needs to be cared for as a care recipient.

[281] As s 104 stipulates, the person concerned must no longer be subject to the criminal justice system. Under s 6(3) of the IDCCR Act, a person who is the subject of an order under s 25(1)(b) of the CPMIP Act is deemed to be no longer subject to the criminal justice system.[193] As J was subject to such an order, J is a care recipient no longer subject to the criminal justice system, as required under s 104. J's position is that either or both of s 104(a) and (b) apply to him.

[282] Both parties agreed that s 102 of the IDCCR Act is analogous with s 84 of the MHCAT Act, which provides for a High Court inquiry into the detention of a person detained under the MHCAT Act. The purpose of the MHCAT Act provisions (or their equivalent) was considered in *Re M*.[194] Greig J found the purpose of s 74 of the Mental Health Act 1969 (the antecedent of s 84 of the MHCAT Act) is to provide additional protection and an additional safeguard to those who may be detained or kept in a mental hospital. It is an important supervisory function of the Court and is a statutory

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193 Affirmed in *H (CA841/2012) v R* [2013] NZCA 628, (2013) 26 CRNZ 628 at [23].
194 *Re M*, HC Wellington, M716/85, 21 April 1986.

expression of the inherent jurisdiction of the High Court to maintain a protective and supervisory function over those who are under disability.

[283] Section 102 of the IDCCR Act provides similar safeguards to those detained in intellectual disability care. Other remedies, such as a review by the Mental Health Review Tribunal under ss 79 or 80 of the MHCAT Act, or the right to be heard on an application to extend a compulsory care order (or to appeal or to review such an order),[195] do not preclude the High Court from exercising its powers under s 102 to conduct an inquiry or under s 104 to make an order that the person cease to be a care recipient.

The issues for inquiry

[284] The issues arising both from the application and the matters arising under s 104 of the Act are:

(a) Is J detained unlawfully as a care recipient because he does not have an intellectual disability?

(b) If J does have an intellectual disability, does J need to be cared for any longer as a care recipient?

[285] Before addressing each of those issues, the procedural steps taken under s 102 of the IDCCR Act, namely the request for reports and the summons of witnesses, should be addressed.

Procedural steps

[286] The provisions governing the s 102 IDCCR Act inquiry empower a High Court Judge to summon witnesses and call for reports on the care recipient or even summon the care recipient himself.[196] The statutory provision also envisages a High Court Judge making an order directing a District Inspector or one or more other persons to visit and examine a care recipient who is detained in a facility.[197] At any stage of the

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195 Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 117.
196 Section 102(1)(b).
197 Section 102(1)(a).

inquiry, whether an order has been made for a District Inspector or other persons to visit and examine the care recipient, a High Court Judge may make an order directing the Care Manager to bring the care recipient before the Judge either in open Court or in Chambers, for examination by the Judge.[198]

[287] The statutory provisions make it clear that an inquiry under s 102 is an inquisitorial process, rather than an adversarial one. On that basis, the Care Coordinator took the role of providing assistance to the Court, rather than opposing the application for J's release as a care recipient.

[288] A total of seven witnesses were called to testify on oath in respect of the two issues before the Court:

(a) the assessment of J's intellectual disability; and

(b) the assessment of risk in respect of J's longer term care.

[289] Those witnesses were called on behalf of the respective parties, who were given an opportunity to cross-examine and re-examine. As the Judge conducting the inquiry, I also questioned the witnesses, where appropriate.

[290] Under s 102, I requested a report from the responsible District Inspector assigned to J, to report on:

(a) any concerns or issues that have been raised with the Ministry of Health specifically over J's status or care;

(b) any information or report that has been made available to the Family Court from the time of Ms Fuata'i's involvement as the IDCCR Act District Inspector; and

(c) any follow-up actions or consultations taken following the direction or any direction of a Family Court Judge.

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198 Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, ss 102(1)(b), 102(2) and 103.

[291] The purpose of such a report was to properly understand the background of J's care and any observations or concerns that may have been raised in respect of J, be it his status as a care recipient under the Act or the level of care he has been receiving.

[292] Ms Fuata'i filed a memorandum in response, accompanied by two memoranda she had filed with the Family Court. These memoranda reported the issues that she had raised specifically with the Ministry. These included:

(a) J's continuing status as a care recipient and the issue of proportionality, i.e. the length of the period of care as a care recipient in the index offending.

(b) The review of J's care and rehabilitation plan six monthly, monitoring reviews, recommendations as to appropriateness of care and rehabilitation as directed by the Courts, concerns raised by J's mother, particularly lack of communication and/or consultation between her and J's staff, proper documentation of observations and serious incidents and timely investigations of incidents by the Care Manager or appropriate person within the service provider's organisation.

[293] In her memoranda to the Family Court dated 9 February 2007, Ms Fuata'i referred to the concerns expressed by J's mother and the justice advocate[199] about the deterioration of J, whilst he has been in care. Ms Fuata'i acknowledged that:

> J's increased containment lends some support to the claim. However, the contention in my humble opinion is extremely simplistic and does not address [J's] complex presentation and ID.

[294] Ms Fuata'i confirmed that J's mother can make contact with her, regarding any concerns or issues over J's care, including the options of funding packages and home modifications for J. Ms Fuata'i confirmed that a significant part of her role in J's case included monitoring processes between agencies involved in delivering care and monitoring J's care and rehabilitation plan, to ensure that the services are delivered

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[199] Justice Action Group representative Ms Old.

appropriately for the purpose of rehabilitation, congruent with J's rights under the legislation.

[295] The Care Manager submitted that it had been agreed between the parties, that should the Court make an order under s 102(2) and should the Court wish to ask any questions of J himself in the process of its examination, the Court should appoint an independent expert to visit J and report back to the Court.

[296] For reasons which I address under issue 1, I did not consider an independent specialist assessor was required, given the number of experienced health assessors that were called by the Care Coordinator for the purposes of this inquiry before the Court, who had interviewed J as part of their respective assessments.

[297] Following the hearing, I received a written letter from J, requesting that he be released into his "number one" house to live with his mother. Dr Ellis for J suggested that I visit J at his current facility and the Care Manager responded, abiding the decision of the Court.

[298] I declined to attend on J at his facility for two reasons. First, the information and evidence which I had heard from specialist assessors and the other witnesses satisfied the issues I needed to address in this inquiry. Second, I also had particular regard to the evidence of a number of witnesses, Dr Judson and Ms Daysh in particular, who described the anxiety and stress experienced by J, when he learns of impending visits by officials or experts whom he has not previously met.

[299] I turn then to consider the first issue.

Issue 1 – Does J have an intellectual disability?

[300] In order to be lawfully detained as a care recipient, the Court must consider the initial eligibility criteria required to detain a person. To make a compulsory care order, the Court must be satisfied, on the evidence of one or more health assessors, of the following three criteria:[200]

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[200] Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 45; and Criminal Procedure (Mentally Impaired Persons) Act 2003, s 25.

(a) the care recipient must have an "intellectual disability";[201]

(b) they must have been assessed under the IDCCR Act. Specifically, a needs assessment must be carried out and a care and rehabilitation plan must be prepared;[202] and

(c) the care recipient is to receive care under a care programme completed under s 26 of the IDCCR Act.

[301] Section 44 of the IDCCR Act is also relevant:[203]

> **44 Court to consider proposed care recipient's condition**
>
> (1) On an application for a compulsory care order, the Family Court must determine whether or not the proposed care recipient has an *intellectual disability.*
>
> (2) If the court considers that the proposed care recipient has an intellectual disability, it must determine *whether or not, having regard to all the circumstances of the case, it is necessary to make a compulsory care order*.

[302] The key issue, therefore, to determining whether or not detention is lawful is whether J has an "intellectual disability".

[303] Section 7 of the IDCCR Act defines an "intellectual disability" as follows:

> **7 Meaning of intellectual disability**
>
> (1) A person has an **intellectual disability** if the person has a permanent impairment that—
>
> (a) results in significantly sub-average general intelligence; and
>
> (b) results in significant deficits in adaptive functioning, as measured by tests generally used by clinicians, in at least 2 of the skills listed in subsection (4); and
>
> (c) became apparent during the developmental period of the person.
>
> (2) Wherever practicable, a person's general intelligence must be assessed by applying standard psychometric tests generally used by clinicians.

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201 See the definition in the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 7.

202 Part 3.

203 Emphasis added.

(3) For the purposes of subsection (1)(a), an assessment of a person's general intelligence is indicative of significantly sub-average general intelligence if it results in an intelligence quotient that is expressed—

(a) as 70 or less; and

(b) with a confidence level of not less than 95%.

(4) The skills referred to in subsection (1)(b) are—

(a) communication:

(b) self-care:

(c) home living:

(d) social skills:

(e) use of community services:

(f) self-direction:

(g) health and safety:

(h) reading, writing, and arithmetic:

(i) leisure and work.

(5) For the purposes of subsection (1)(c), the developmental period of a person generally finishes when the person turns 18 years.

(6) This section is subject to section 8.

[304] Section 8 defines persons who do not have an intellectual disability as follows:

8 Persons who do not have intellectual disability

(1) A person does not have an intellectual disability simply because the person—

(a) has a mental disorder; or

(b) has a personality disorder; or

(c) has an acquired brain injury; or

(d) does not feel shame or remorse about the harm that person causes to others.

(2) To avoid doubt, if—

(a) a person does not have an intellectual disability, the provisions of this Act relating to compulsory care cannot apply to the person, whether or not the person has any other disability:

(b) a person does have an intellectual disability, those provisions are not prevented from applying to the person simply because the person also has 1 or more of the characteristics described in subsection (1)(a) to (d).

[305] Whether a person has an intellectual disability, is therefore a question of fact to be determined by medical evidence. For the purposes of a person's general intelligence, this must be assessed by applying standard psychometric tests, as s 7(2) provides. Those tests are carried out by clinical psychologists.

The examination of witnesses

[306] Seven witnesses, including six expert witnesses, were called by the parties for the purposes of the Court's examination in this inquiry. On behalf of J, two affidavits were also filed, one by J's welfare guardian, his mother, who describes J's excellent memory; his artistic ability and his ability to read, pronounce and spell long and difficult words. The second is an affidavit from Ms Old from the Justice Action Group. She also describes her support of J's mother and her visits to J at his care facility, Te Roopu Taurima O Manukau Trust (TRT), where his talk about James Bond is easily redirected. She describes J's interest in animals and television programmes about animals, his interest in music, his ability to play the guitar and sing, his "astonishing memory" and her opinion that he is a very fast learner. There was no cross-examination of these witnesses.

[307] Two experts were called on behalf of J. The first was Dr Olive Webb, who undertook an assessment and testing of J's intellectual functioning for the Family Court review in February 2017[204] and revisited her opinion in this inquiry. The second witness was Professor Paul Barrett, who challenged the "measurement" and the veracity of IQ test scores in the assessment of J's intellectual functioning.

[308] The Care Coordinator called four expert witnesses and Ms Daysh, the manager of NIDCA.[205] I return to consider her evidence under issue 2.

[309] The Care Coordinator's four witnesses were:

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[204] The hearing before Judge Goodwin is the subject of the Family Court appeal, addressed in Part 2 of this judgment.

[205] National Intellectual Disability Care Agency.

(a) Ms Louisa Medlicott, who is an expert clinical psychologist specialising in the area of intellectual disability for over 20 years. She was called to provide expert clinical opinion on IQ testing generally, the impact of autism on IQ testing and whether J met the criteria for intellectual disability under the IDCCR Act. She was also asked to give evidence on the general use of risk assessments by specialist assessors, how they applied to people with intellectual disabilities and comment on the evidence of Dr Webb and Professor Barrett.

(b) Dr Nicol Wilson, who is a registered clinical psychologist with expertise in risk assessment of offenders, with a focus on those with intellectual disability and autism spectrum disorder (autism). He was also asked to comment on the validity of two risk assessment tools, the HCR-20 and LS/CMI generally.

(c) Ms Beata Torok, who is a clinical psychologist and a specialist assessor, who undertook a s 79 IDCCR Act assessment of J on 11 April 2017.

(d) Dr Nick Judson, who is a consultant psychiatrist with the mental health intellectual disability team at Te Korowai-Whāriki, who carried out a s 79 IDCCR Act specialist assessor review of J on 21 June 2017.

Prior evidence of intellectual disability

[310] The starting point in an inquiry into J's cognitive assessment is the 2005 assessment by clinical psychologist Ms Breen. Ms Breen used the Wechsler Adult Intelligence Scale – Third Edition (WAIS-III), which is an individually administered test of intellectual level. It is made up of 11 compulsory and three optional sub-tests, which each assess a person's ability to perform a different task of intellectual functioning. Performance is reported as intellectual quotients (or "IQ scores"), which in turn are summaries of intellectual functioning. Thus, a person's IQ is compared to those of a large sample of people in the same age range.

[311] The FSIQ comprises Verbal IQ (VIQ), covering acquired knowledge, verbal reasoning and attention to verbal materials, and Performance IQ (PIQ), which

summarises fluid reasoning, spatial processing, attentiveness to detail and visual motor integration. The FSIQ is used to calculate the intellectual level of the person being tested. For most people, the FSIQ is between 85 and 115. Scores in the low 80's are described as "below average" and in the high 70's are described as "borderline". Intellectual disability is indicated when a person's IQ is below 70–75. Intellectual disability is mild when the FSIQ is between 55–70; moderate when between 40–54; severe when between 25–40 and profound when under 25.

[312] Ms Breen administered 13 sub-tests of the WAIS-III to J. J's FSIQ score indicated to Ms Breen that J had a "mild" degree of intellectual disability (FSIQ between 58–68, at 95 per cent confidence level). In relation to other people, Ms Breen reported that J's percentile rank was 0.5. If 100 randomly selected people of his age were ranked in order in this test, 99.5 would score better than J.

[313] Ms Breen reported the scores as follows:

> [J's] VIQ (53; percentile rank 0.1) and PIQ (78; percentile rank 7) were significantly different from each other. Only 2.6% people would show similar differences. Therefore index score analysis was undertaken. The WAIS-III index scores allow identification of different skill areas and enable comparison between these areas to identify areas of strengths and weakness. These are Verbal Comprehension (VCI), Perceptual Organisation (POI), Working Memory (WMI), and Processing Speed (PSI). [J's] index score results are as follows:
>
> - The Verbal Comprehension Index (VCI) provides a measure of verbal knowledge and understanding, obtained through both informal and formal education. The score reflects the ability of the person to apply verbal skills to new situations. [J's] VCI was 55, his percentile rank was 0.1. [J's] verbal comprehension was therefore very poor.
>
> - The Perceptual Organisation Index (POI) reflects an individuals' ability to interpret and organise officially received material, within a time limit. [J's] POI was 89, his percentile rank was 23. [J's] perceptual organisation was in the low average range. This was [J's] strength.
>
> - The Working Memory Index (WMI) provides information about a person's ability to attend and concentrate on a task, and involves assessment of numerical proficiency, short-term memory, sequencing, and the ability to self-monitor. [J's] WMI was 50, his percentile rank was less than 0.l. [J] had extremely poor skills in this area.
>
> - The Processing Speed Index (PSI) provides a measure of a person's ability to process visually perceived non-verbal material with speed. [J's] PSI was 60, his percentile rank was 0.4. [J's] processing speed was very poor.

[314] In the same assessment, Ms Breen used the Vineland Adaptive Behaviour Scales (VABS-E), which is a checklist of the skills that collectively are described as indicators of a person's adaptive functioning.[206] Ms Breen concluded that J's VABS-E profile indicated his adaptive functioning overall was profoundly deficient, particularly in J's ability to use skills required for everyday living. In comparison with people of his own age, Ms Breen concluded that over 99.9 per cent of adults would function better than J on this test.

[315] Ms Breen summarised J's communication skills as profoundly deficient and equivalent to a three year, five month age level. J's daily living skills were also severely deficient, estimated to be at the five year, six months age level. J's socialisation skills were also profoundly deficient and equated to be at an age of two years, 11 months.

[316] With the conclusions that J's FSIQ was in the range of 58–68 and his adaptive functioning overall was profoundly deficient, Ms Breen concluded that J fulfilled the criteria required for a diagnosis of intellectual disability under the IDCCR Act.

The Family Court specialist assessors' reports

[317] J was assessed by two specialist assessors, Dr Thomson and Ms Jensen, under ss 77(2)(c) and 78 of the IDCCR Act, for the purposes of the Family Court review of J's compulsory care order in February 2017. The relevant detail of these reports has been canvassed in Part 2 of this decision.[207]

[318] Both specialist assessors confirmed that after assessing J, the 2005 assessment by Ms Breen was still valid. Ms Jensen observed there was no evidence to suggest there had been a substantial improvement in J's functioning since the 2005 assessment and his intellectual disability is a permanent impairment. Dr Thomson observed that J's intellectual disability is a life-long condition, with little prospect of his transcending it. Further, he concluded, J needs a high level of support to achieve the

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206 Expanded edition of Vineland Adaptive Behaviour Scales.
207 At [188]–[193] of this judgment.

daily requirements of his life, "which is the other important aspect of a diagnosis of intellectual disability".

Dr Webb's assessment and opinion

[319] Dr Olive Webb is a registered clinical psychologist and has worked in the area of intellectual disability for over 45 years, publishing widely in the field of intellectual disability and autism. At the request of J's welfare guardian, Dr Webb undertook an assessment of J's intellectual functioning in 2016, prior to the Family Court hearing in 2017. In giving evidence to the Family Court, Dr Webb described J's intellectual functioning as follows:

> (a) He has an unusual pattern of cognitive abilities. Whilst he has average visual problem-solving skills, his other cognitive functions are extremely low.
>
> (b) Specifically, his verbal understanding and general knowledge are extremely low and [J's] Working Memory Index score suggests that he has very little ability to use knowledge and skills that he might accrue in the course of his daily activities to make daily decisions and solve problems.
>
> (c) [J] should be considered to have intellectual disabilities and so eligible for support under the terms of the IDCC&R Act.

[320] Following the hearing before Judge Goodwin in the Family Court, Dr Webb was challenged by Dr Ellis about her interpretation of the test scores she had obtained on the measurement tools used. As a result of that challenge, Dr Webb reviewed the relevant current literature and current practice in the assessment of intellectual functioning in people with autism. Because of the divergence in the literature and practice, Dr Webb revised her opinion, in giving evidence to this inquiry hearing.

[321] Dr Webb opined that the poor scores in the WAIS IQ test were consistent with the research relating to the nature and assessed level of intelligence in people with moderate to severe autism. Thus, J's poor scores were not necessarily the result of J's cognitive abilities from an intellectual disability, but resulted from the influence of autism on J's intelligence test results.

[322] Dr Webb questioned the validity, appropriateness and usefulness of the assessment of intelligence in people with moderate to severe autism. The problem that

exists in New Zealand, Dr Webb explained, is that the definition of intellectual disability in the IDCCR Act is rigidly enshrined as an IQ of 70 plus/minus five, plus two or more adaptive deficits, and onset before the age of 18 years, which does not allow for the impact or influence of disorders such as autism. Dr Webb opined that on the basis of the test scores and those obtained by other clinical psychologists, it is difficult to conclude J has an intellectual disability. She considered that the derivation of the FSIQ, as s 7(3) of the IDCCR Act requires, is not clinically valid.

[323] On the basis of Dr Webb's conclusion, Dr Ellis submits that if J's FSIQ score, of less than 70–95 per cent confidence level cannot be met, then the statutory definition of IQ cannot be met and therefore J cannot be detained under the IDCCR Act. He submits that Dr Webb is the only one who has tested J, since 2005 when Ms Breen undertook her testing. If Ms Breen's testing is based on this "same unreliable testing" that Dr Webb concludes now is inappropriate, then Ms Breen's evidence may either be inadmissible or too unreliable.

[324] In her summary of conclusions, Dr Webb referred to some of J's IQ scores, namely his 2005 WAIS-III Index and Performance IQ scores, his 2016 Raven's Progressive Matrices and some of his 2016 WAIS-IV index scores. Dr Webb says these indicate J's fluid reasoning skills are high and the low scores obtained on the WAIS-III index are low, because of the effects of his autism on his communication, processing speed and working memory skills. His General Ability Index (GAI) was only on the cusp of intellectual disability, because it is less affected by his autism related deficits.

[325] Because J's support staff have largely taken a role of "minders" and there had been few interventions targeting J's autism related deficits, Dr Webb recommended a re-assessment at years end, using different tools, to assess whether J is still intellectually disabled.[208] Dr Ellis submits that with J's autism deficits being treated, J might not now be assessed as intellectually disabled.

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[208] Dr Webb suggesting listing the following tools: Stanford-Binet 5, WAIS-V (when it is released), a repeat Raven's Progressive Matrics assessment and complementary and concurrent assessments by occupational therapists and speech language therapists.

[326] In order to analyse Dr Webb's challenge to the clinical validity of the FSIQ scores required by s 7(3) of the IDCCR Act, and Dr Ellis' submissions, I consider it is important to canvass Dr Webb's evidence both in the Family Court and before this Court.

Dr Webb's Family Court evidence

[327] Dr Webb undertook an assessment of J's intellectual functioning, at the request of J's welfare guardian, and presented her conclusions in her report of 13 November 2016, as the basis of her evidence in the Family Court review proceedings. The results of Dr Webb's psychometric assessment of J's cognitive functioning were as follows:

> (a) On the Raven's Progressive Matrices, which is a non-verbal test involving solving problems with just visual material and does not involve language, J scored on the fourteenth percentile on the Matrices, which is an estimated IQ of about 84.[209] This is in the borderline-low average range.
>
> (b) On the Peabody Picture Vocabulary Test, J scored on the second percentile. J's ability to recognise the meaning of words as presented pictorially to him was in the extremely low range.
>
> (c) The Wechsler Adult Intelligence Test WAIS-IV confirmed the unusual pattern of abilities, suggested by the other two tests:
>
> (i) J's perceptual reasoning index was in the low-average range with a Matrix Reasoning sub-test score on the fifth percentile but his score on the Block Design sub-test (involving copying visual patterns) was on the fiftieth percentile, in the average range.[210]
>
> (ii) J's Verbal Comprehensive Index, assessing his vocabulary, general knowledge and ability to work with abstract concepts was extremely low, at the 0.2 percentile level.
>
> (iii) J's Working Memory Index (the ability to store information and use it to solve problems) was even lower at 0.1 percentile, in the extremely low range.
>
> (iv) J's ability to solve problems was in the extremely low range, with his processing speed index at the 0.3 percentile.

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209 This test is considered to correlate about 0.8 with a full-scale WAIT (the most comprehensive intellectual assessment) score.

210 A test similar to the Raven's Progressive Matrices.

[328] Dr Webb aggregated J's pattern of scores to produce a FSIQ of 60, in the extremely low range. Dr Webb concluded J's General Ability Index (GAI), which is an aggregated score that is less sensitive to the influence of working memory and processing speed than J's FSIQ, was 70, also in the extremely low range.

[329] As a result of these tests, Dr Webb reached the following overall conclusions:

> [J] has an unusual pattern of cognitive abilities. Whilst he has average visual problem-solving skills, his other cognitive functions are extremely low.
>
> Specifically, his verbal understanding and general knowledge are Extremely Low and [J's] Working Memory Index score suggests that he has very little ability to use knowledge and skills that he might accrue in the course of his daily activities to make daily decisions and solve problems.
>
> He should be considered to have intellectual disabilities and so eligible for support under the terms of the IDCC&R Act.

[330] It is also pertinent, that although not requested to provide such an opinion for the Family Court, Dr Webb concluded that J was not fit to plead and could have little understanding of the Family Court review proceedings.

[331] In the hearing before the Family Court, Dr Webb confirmed her conclusions from her report and explained how she could make a finding of intellectual disability, despite the variance in the scores obtained from J.

[332] At the Family Court review hearing, Dr Webb was cross-examined by Mr Auld, for the Care Coordinator, about her conclusion in her report, that J should be considered to have intellectual disabilities and be eligible for support under the IDCCR Act.

> Mr Auld: I think you conclude in your report that … [J] should be considered to have intellectual disabilities and so eligible for support under the terms of the IDCCR.
>
> Dr Webb: Yes.
>
> Mr Auld: So you agree with that essentially do you?
>
> Dr Webb: Yes, yes I mean … in any other context you actually wouldn't calculate the IQ for [J] because the two figures are so different.
>
> Mr Auld: Yes.

Dr Webb: And the … reality is that the effect of his autism is to effectively suppress his verbal cognitive skills and that is his intellectual impairment.

[333] At this point, Judge Goodwin interpolated and asked Dr Webb:

Court: … Do you mean that his autism means that it affects his communication to an extent that it throws the IQ test out, is that what you mean?

Dr Webb: Yes, it affects his communication both ways, so he not only doesn't – he's actually not that bad at expressing himself simply, but he doesn't understand stuff so if – when I asked him a little bit complex question he just couldn't compute it.

Court: … so are you saying in layman's terms that he doesn't have an intellectual disability? What he had is autism that means you can't – it throws the IQ test out, is that what … you're saying?

Dr Webb: No, no, no. The definition of intellectual disability is not predicated on why.

Court: Yes.

Dr Webb: It's a[n] empirical test of what is and how [J] functions now, for all intents and purposes we can put a ring around those lovely visual perceptual skills, but in all other areas he really has an intellectual disability.

Court: Sorry, he really …?

Dr Webb: He does have an intellectual – yes.

Court: He does have? Okay, alright.

[334] In re-examination Dr Ellis asked Dr Webb about the impact of a brain injury on intellectual disability testing:[211]

Dr Ellis: Is this that rare event that if you had a brain injury after 18 you wouldn't be intellectually disabled but you'd still be needed for intellectual disability – are we in that area?

Dr Webb: No.

Dr Ellis: Or not?

Dr Webb: … few years, decades ago we used to worry about what intelligence is, and the general accepted definition went something like, "The ability to remember things that have happened to you and to learn from events in order to increase your adaptation," or something … and you know, the pragmatists then said,

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211 Emphasis added.

> "Intelligence is what intelligence tests measure," and that's usually the, sort of, the fallback position. But it's that ability to learn from prior experience and to incorporate that learning into your ongoing life, [which] has been the – the sort of the cornerstone definition of intelligence. As far as the tests are concerned, usually when people sit the WASI-type IQ tests, the test is made up of 10 or 11 sub-tests and usually if I have an I – an average IQ, I will have average perceptual skills, average verbal skills, average prompt – you know? It will all happen there quite… People with autism have – and other people with different syndromes – sometimes you get that distribution of scores skewed and so we have all of these perceptual sub-tests and all of the verbal sub-tests. **Now, the Raven's correlates with part of the WASI and so that's why – that's why the – it seems very high compared to the overall. It's because the – the abilities are skewed and it correlates only with that part of the WASI because he scored quite – I think 50th percentile on one sub-test in – in the WASI, but these scores are right down so this means he can't understand what people are saying to him, he can't solve problems, he can't learn from his experiences in the usual way and so that makes him intellectually disabled.**

[335] As part of her overall conclusions, Dr Webb recorded that because of J's deficits, he was dependent on other people to help him understand and respond to situations and other people. He cannot independently anticipate events and his responses to them, nor can he independently plan and execute actions. Dr Webb did not conduct an assessment of J's adaptive functioning. However, she does record that there was consensus among those she had consulted that J's support, until as recently as November 2016, had been inadequate and it is likely that this was a factor in his continuing behavioural challenges.[212]

Dr Webb's evidence in this inquiry

[336] As set out above,[213] Dr Webb questioned the validity of testing J's intellectual functioning using the FSIQ tests, as the derivation of the FSIQ is not clinically valid because of the variance in J's test scores. Dr Webb also raised the effect of medication on IQ testing. In her assessment of J, she told the Court that she knew J was on medication but was "quite chirpy bordering on playful" and did not come across as being sedated at the time.

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212 This matter is further canvassed under the next issue of whether J should be under a compulsory care order.

213 At [322] of this judgment.

[337] Dr Webb was cross-examined on her opinion expressed in the Family Court that J had an intellectual disability. Dr Webb agreed that the answer she gave in the Family Court was still valid and acknowledged that J's deficits make him intellectually disabled. The passage is as follows:

> Mr Auld: But just returning to the answer you gave in the Family Court, and you've said that what the scores mean is that he can't solve problems, he can't learn from his experiences in the usual way and so that's what makes him intellectually disabled. So I suppose my question to you is that if we take the definition of intellectual disability that we discussed, which seemed to focus on the impact of those deficits in someone's life, do you not agree that the answer that you gave in the Family Court is still valid, that he's not able to do these things and therefore he has an intellectual disability?
>
> Dr Webb: There is one other score within the WAIS-IV, and that's the general ability index, which is an attempt to get a measure of the other intelligence, if you like, less affected by those elements that are suppressed by the autism and on that, it's not a full-scale, it's not an option to a full-scale IQ, but it is another number to consider. Again, when people's intellectual sub-test scores are fairly even, the GAI will approximate or will be similar to the full-scale. …
>
> Mr Auld: Whether the answer you gave in the Family Court the fact that these deficits have led to the fact that he can't understand what people are saying to him, can't solve problems and can't learn from his experiences in the usual way then so that makes him intellectually disabled?
>
> Dr Webb: That's what I said in the Family Court, yes.
>
> Mr Auld: Do you now accept that that's still valid?
>
> Dr Webb: Yes it's still valid but it is different in him from other people who are intellectually disabled and can't do those things.
>
> Mr Auld: And that's because he has one particular strength and you say, sorry, he has this one particular strength, you agree?
>
> Dr Webb: Yes.
>
> Mr Auld: And what you said before is that we should look at the strengths because that helps us to identify what we can utilise for support and treatment, is that right?
>
> Dr Webb: Yes.
>
> Mr Auld: So again I put it to you, Ms Medlicott will say that the best way of describing it is that he generally has significantly sub-average general intelligence but he has this one strength and that's essentially how it can be reported, do you accept that?
>
> Dr Webb: Yes I accept that, yes.

[338] Following the cross-examination of Dr Webb, I formed a preliminary view that Dr Webb was not challenging whether J had an intellectual disability but rather, expressing her concern about the way he was being cared for, given his disabilities of autism and intellectual disability. I sought confirmation from Dr Webb on this view and Dr Webb agreed. The transcript records it as follows:

> Court: … Now I wanted to just ask you whether the effect of your evidence yesterday … whether what you are saying is that it's not so much whether J has an intellectual disability, because I think you've conceded he does have an intellectual disability as we have it defined in the Act. Am I right about that?
>
> Dr Webb: Yes.
>
> Court: But your concern is how he is cared for, how the level of interaction with him, given his disability, is accommodated. Am I correct about that?
>
> Dr Webb: The short answer is yes and the problem is that … it seems that he has been regarded, in terms of interventions, just in terms of the intellectual disability, whereas it is his autism that is driving the other behaviours of concern …

[339] Dr Webb also clarified the difference between the assessments of J's cognitive skills, compared to his adaptive skills or areas of functioning ability. Dr Webb confirmed that in J's adaptive functioning, there were at least two of these skills that J is not able to get beyond an average score, particularly in communication and social skills, but also self-direction and possibly health and safety. All assessments had regard to the initial psychometric testing of Ms Breen and upheld her findings (albeit that Dr Webb's FSIQ score of 60 differed slightly to the range of 58–68 by Ms Breen) and J's intellectual disability assessment continued to be valid.

The use of psychometric testing for intelligence testing

[340] In light of J's challenge to the use of psychometric testing for assessing general intelligence, evidence was called from two experts to address the validity of the psychometric tests for general intelligence testing and their impact on the assessment of intellectual disability.

[341] Professor Barrett was called by Dr Ellis on behalf of J, to give expert evidence on the "measurement" of psychometrics and the veracity of test scores. Professor

Barrett is not a clinical psychologist, so did not express an opinion as to the clinical diagnosis of J as intellectually disabled. His evidence focused on the reliability and variability of J's test scores and how this affects a meaningful FSIQ score.

[342] The Care Coordinator called Ms Medlicott, who is a clinical psychologist and specialist in the area of intellectual disability, which she has practised in for over 20 years. She has been a moderator for the Ministry of Health on the work of specialist assessors; she has completed reports as a health assessor under the CPMIP Act and is a specialist assessor under the IDCCR Act. The evidence from both Professor Barrett and Ms Medlicott was expansive and helpful in describing the types of IQ test tools and the way in which those measures are applied to achieve a comprehensive IQ test in respect of an individual's intellectual functioning.

[343] I do not intend to canvass the detail of their expert evidence, because there is agreement from all three witnesses, Dr Webb, Professor Barrett and Ms Medlicott, on the use of IQ scores to diagnose intellectual disability. All three experts agree that reliance on an IQ score alone cannot be a precise quantitative measure of general intelligence or the only way to diagnose intellectual disability. Each of the experts describe this in different ways.

(a) Dr Webb challenged the rigid definition of an IQ test score as being inappropriate for persons with autism and notes that a number of professional bodies, including the American Association on Intellectual and Development Disabilities (AAIDD) discouraged strict reliance on IQ scores to diagnose intellectual disability and should be provided as a guide. There must be room for the clinician to make the appropriate judgement based on the assessed needs of the person.

(b) Ms Medlicott, in refuting a number of Dr Webb's conclusions, referred to the operational guidelines released by the Ministry of Health, in which the Ministry stated:[214]

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[214] Ministry of Health *Operational guidelines for the assessment of intellectual disability to access disability support services contracted for people with intellectual disability in New Zealand*, (2012).

> The IQ should not be used as a cut-off measure. This number is only important to the psychologist in context with the other supporting information.

Ms Medlicott reinforced that it is not correct to characterise s 7(3) of the IDCCR Act as requiring an FSIQ of 70 or less before a person is defined as intellectually disabled. In her view, it is an indicator to be used where clinically appropriate but is not an absolute direction. She too refers to the AAIDD guidelines which say:[215]

> The IQ test is a major tool in measuring **intellectual functioning**, which is the mental capacity for learning, reasoning, problem solving and so on. A test score below or around 70–or as high as 75–indicates limitation in intellectual functioning.
>
> … AAIDD stresses that, in addition to an assessment of intellectual functioning in adaptive behaviour, professionals must consider such factors as community environment typical of the individual's peers and cultures; linguistic diversity; cultural differences in the way people communicate, move, and behaviour.

Ms Medlicott stated further that:

> While a valid FS IQ is the ideal way of indicating that a person meets the first criteria for the diagnosis of an intellectual disability, examining the overall pattern of results and using clinical judgment is also important when considering any diagnosis of functioning.

(c) Professor Barrett concluded that it is presumptive to insist that an IQ score of any description is a precise quantitative measure of "general intelligence" or intellectual disability. He concluded that in J's case, any such assessment must necessarily rely upon clinical expertise and judgement, in which the estimates of specific cognitive abilities provide useful contributory information to aid formulation and eventual diagnosis. As he concluded, "no single IQ score can be taken as indicative of an individual possessing a clinical diagnosis or symptoms

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215 "Frequently Asked Questions on Intellectual Disability" American Association on Intellectual and Development Disabilities <www.aaidd.org>.

which also manifest themselves in particular kinds of intellectual deficit."

(d) Professor Barrett accepted the same propositions under cross-examination, acknowledging that IQ test scores are useful tools for informing a clinical analysis of someone's level of general intelligence. He accepted they have a pragmatic purpose and that the score range can be meaningful about someone's general intelligence. He also accepted that what one does with that information requires an additional level of analysis, which is the clinical judgement of an experienced clinical psychologist.

[344] The experts agreed that IQ scores alone should not form the basis of an intellectual disability diagnosis. This accords with the legislative history and the scope of the definition of intellectual disability under the IDCCR Act. I have already referred to the select committee stage of the Intellectual Disability (Compulsory Care) Bill, where the Health Select Committee had specific regard to the inclusion of both the IQ scores and significant deficits in adaptive functioning skills.[216] Parliament had specific regard to the need to avoid a rigid definition of IQ that uses just an intelligence quotient.

[345] Section 7(2) of the IDCCR Act contemplates that general intelligence should be assessed "wherever practicable", which indicates Parliament foresaw that there will be cases where it is not practicable to determine general intelligence through psychometric testing. Similarly, the criteria outlined in s 7(3) reinforces that psychometric testing is "indicative of" significantly sub-average general intelligence, reinforcing that it is a guide only to the overall definition of intellectual disability.

[346] Dr Webb agreed, under cross-examination, that a diagnosis of intellectual disability requires the use of overall clinical judgment as to whether a person has an intellectual disability, rather than a rigid reliance on the IQ score. Further, Dr Webb agreed that the IDCCR Act and the various diagnostic classification systems provide for a clinical decision on the diagnosis of intellectual disability. This view was

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216 At [182] of this judgment.

supported by Ms Medlicott, who gave as an example some people who have significant differences in their intellectual functioning. Dr Medlicott provided examples of varied intellectual profiles, where a person may have a pattern of relative strengths and weaknesses in intellectual functioning, but there must be a careful clinical consideration of such patterns, before concluding that an FSIQ can be validly made. A person may score highly in one area, e.g. the 95th percentile in some areas and the 5th percentile in others, but this should not be averaged to show "average functioning" by an FSIQ score at the 50th percentile. To do so, would ignore the significant and unusual spread of intellectual functioning and likely spread of ability in managing their day to day life and world.

[347] Then Ms Medlicott described some people who cannot be assessed, and in her experience, IQ test scores cannot be obtained. This can occur where a person has extreme cerebral palsy, as Ms Medlicott described, and it is very difficult to obtain a psychometric assessment. In those cases, the clinical psychologist can diagnose intellectual disability, without a psychometric assessment, or obtaining a FSIQ test as the Act provides.

[348] Turning then to the variability of J's test scores, Ms Medlicott referred to the academic literature, advising the clinician to select a measure, be it FSIQ or GAI, that provides the "most sensible overview" of the person's functioning.[217] The clinician is to use clinical judgement in doing so. Importantly, clinicians are encouraged to report the overall score in order to make a diagnosis but to use their clinical skills and ability to consider the overall behaviour of the person being assessed, as well as the pattern of results, before presenting such information. She also stressed that J's intellectual functioning should not be based solely on resulting scores such as the Ravens test, but conclusions on J's functioning should be made using structured clinical judgement.

[349] Ms Medlicott reviewed the evidence of Ms Breen and Dr Webb's testing of J, in the assessment of J's general intelligence. She reached the same conclusion as both Ms Breen and Dr Webb. Ms Medlicott concluded that no firm conclusion should be reached on either one of the specific tests, but should be looked at, taking into account

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[217] Elizabeth Lichtenberger and Alan Kaufman *Essentials of WAIS-IV Assessment* (2nd ed, John Wiley and Sons, New York, 2012).

J's overall range of intellectual and cognitive abilities. In her view, those indicate that J has significantly sub-average intellectual functioning.

[350] Although Professor Barrett said it was not practicable to assess J's general intelligence solely through the use of psychometric tests, he did agree that a low IQ score with a tool such as the WAIS-IV would be indicative of significantly low general intelligence.

[351] Professor Barrett was also asked about the margin of error in obtaining IQ scores using standard psychometric tests. He cited the research paper written by Simon Whitaker, which suggests a margin of error of up to 25 points above or at least 16 below the measured test is possible using a standard psychometric test.[218] However, Professor Barrett described that approach as a "no-no". He said that plus or minus 12 was a reasonable margin of error for the WAIS test.

[352] In extrapolating that margin of error to the FSIQ score of 60 by Dr Webb, he said the margin of error could, at its highest, be 72. Even given this margin of error, Professor Barrett reinforced to the Court that the range of FSIQ score could be plus or minus 10, but at the end of the day the numbers are not the final result. The ultimate assessment must be informed by clinical judgement, which he described as a qualitative difference.

Conclusion

[353] The evidence overwhelmingly confirms that J has an intellectual disability and he is thus lawfully detained. There may be variance in the application and the final assessment of IQ scores, depending on the use of the various psychometric testing tools. However, both the scores achieved by Ms Breen and Dr Webb, even with Professor Barrett's plus or minus 12 margin of error for the WAIS test, gives a low IQ score, indicative of J's significantly low general intelligence.

[354] With each of the respective scores, 60 (Dr Webb) and the range of 58–68 (Ms Breen), both clinicians reached the view that J's overall functioning was at an

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[218] Simon Whitaker "Error in the estimation of intellectual ability in the low range using the WISC-IV and WAIS-III" (2010) 48 Personality and Individual Differences 517.

extremely low level. J should therefore be considered to have an intellectual disability under the IDCCR Act. All witnesses agreed that at the end of the day, clinical judgement from an experienced assessor was required to arrive at a diagnosis of intellectual disability.

[355] In this case, I am satisfied, on the balance of probabilities, that J has an intellectual disability, as confirmed by the experts from whom I heard and the specialist assessors' reports and evidence, J is lawfully detained.

Issue 2 – Does J need to be cared for as a care recipient any longer?

[356] Having found that J is lawfully detained, as he meets the statutory criteria under s 7 of the IDCCR Act and is intellectually disabled, the next issue I must address is whether J needs to be cared for as a care recipient any longer.

[357] Section 104 of the IDCCR Act is framed on the basis of a cessation of a compulsory care order. The wording is:[219]

> After the examination, under s 102(2), of a care recipient no longer subject to the criminal justice system, the Judge may order that the care recipient cease to be a care recipient if the Judge is satisfied–
>
> …
>
> **(b) that the care recipient no longer needs to be cared for as a care recipient.**

[358] The statutory wording in s 104(b) mirrors the review provisions under s 82 of the IDCCR Act, which provide for regular review of care recipient's orders and care, by specialist assessors, as occurred in the Family Court review hearing on the extension of J's compulsory care order.

[359] Section 82 provides:[220]

> When a specialist assessor completes a certificate, under section 79, in respect of a care recipient no longer subject to the criminal justice system or a special care recipient who is liable to detention under a sentence, the specialist assessor must state whether in his or her opinion—
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> (a) the care recipient still needs to be cared for as a care recipient; or

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219 Emphasis added.
220 Emphasis added.

(b) the care recipient no longer needs to be cared for as a care recipient.

[360] The Court of Appeal in *RIDCA* determined the factors and defined the guiding principles in relation to extension of compulsory care order of care recipients under the IDCCR Act.[221] As the statutory wording in ss 82(b) and 104(b) is the same and as both parties agree, those factors in *RIDCA* are the most relevant to apply to considering s 104(b) in this inquiry. It is important therefore to set out the Court of Appeal's approach to extension decisions. I have summarised this approach below:

(a) Sections 3 and 11 of the IDCCR Act set out the guiding principles in relation to extension decisions. The question to be determined is whether J no longer needs to be cared for as a care recipient. This is the same question a Judge must take into account, when the specialist assessor states their opinion that the care recipient still needs to be cared for as a care recipient. The most recent certificates under s 79, should be taken into account when undertaking the balancing exercise between the community protection interest and the liberty interest of the care recipient.

(b) The Judge must be satisfied that the community protection interest cannot be met other than by a compulsory care order i.e. the compulsory care order must be the least coercive and restrictive option available.

(c) If a care recipient no longer constitutes a risk of sufficient seriousness to justify the continuation of the compulsory care order, an extension (or continuation under s 104(b)) should be refused.

(d) Because rehabilitation is an important objective of the IDCCR Act, the Judge should be informed of the rehabilitation efforts, their outcome, and be advised of the prospects of future rehabilitation.

(e) If the risk posed by the care recipient is unlikely to be reduced through rehabilitative efforts, the Judge may take that into account in

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221 *RIDCA*, above n 64.

determining whether the community protection interest continues to be outweighed by the liberty interest of the care recipient.

(f) The weight to be given to the liberty interest is not necessarily static. After the care recipient has been subject to a compulsory care order for a substantial period, the Judge may determine that greater weight needs to be given to the liberty interest. The nature of the original offending is relevant to an extension decision in that it may provide the Judge with an indicator of the level of risk posed by the care recipient. In a finely balanced case, the fact that an extension would make the period of compulsory care disproportionate to the offending of the care recipient may also be taken into account.

(g) In a case where a Judge is satisfied that the community protection interest outweighs the liberty interest of the care recipient, the fact that the period during which the care recipient will remain subject to a compulsory care order would exceed the sentence to which he or she would have been subject if not intellectually disabled, should not lead to the refusal of an extension. The community protection interest will overwhelm the liberty interest in a case where the minor nature of the offending does not provide an accurate guide to the level of risk posed by the care recipient. In that case, the Court considered it unlikely that a dangerous person could be released because the nature of the offending was taken into account in the risk assessment.

[361] Those factors have been recently confirmed by two Court of Appeal decisions, where the Court considered respectively the basis for making a special care order under s 24(2)(b) of the CPMIP Act[222] and a special patient order under s 24(2)(a) of the CPMIP Act.[223] In *H v R*, the Court of Appeal reinforced the balancing exercise a Court undertakes in making a care order:[224]

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222 *H v R*, above n 193, at [26].
223 *M (CA819/11) v R* [2012] NZCA 142, (2012) 28 FRNZ 773.
224 *H v R*, above n 193 (footnote omitted).

> [10] In determining whether to make either a special care or a care order, the court is undertaking a balancing exercise which involves the need to protect the public from persons who may reoffend while subject to an incapacity (on the one hand) and the desirability of rehabilitating the defendant (on the other). The court must consider relevant aspects of the public interest, the purposes for which the disposition order is being made, and the consequences (to both the public and the defendant) of making either a special care or a care order.

Guiding principles

[362] In addition to the purposes in s 3 of the IDCCR Act,[225] the principles governing the exercise of powers under the IDCCR Act are paramount. Section 11 provides that every court or person who exercises a power under the IDCCR Act in respect of a care recipient must be guided by the principle that the care recipient should be treated so as to protect –

(a) the health and safety of the care recipient and of others; and

(b) the rights of the care recipient.

[363] I propose to apply the s 11 principles and the Court of Appeal factors in *RIDCA* to the assessment of whether J no longer needs to be cared for as a care recipient, by considering the following matters:

(a) The community protection interests:

  (i) the risk assessments;

  (ii) the validity of the risk assessment tools; and

  (iii) any reduction of risk by rehabilitation.

(b) J's liberty interests:

  (i) the relevance of the index offending; and

  (ii) the lowest level of compulsory care required to achieve community protection.

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[225] (a) provide the courts with appropriate options for the detention, assessment, and care of defendants and offenders with an intellectual disability:
(b) recognise and safeguard the special rights of individuals subject to the IDCCR Act:
(c) provide for appropriate use of different levels of care for individuals subject to the IDCCR Act.

(a) The community protection interests

The risk assessments

[364] J has been formally assessed (as canvassed under the first issue) four times in less than 12 months prior to the High Court hearing. The specialist assessors who completed their certificates under s 79 for the Family Court review hearing were Dr Thomson and Ms Jensen, to whom I have already made considerable reference. In preparation for this High Court inquiry, Ms Torok and Dr Judson both completed s 79 certificates, certifying that in their opinion, J still needs to be cared for as a care recipient. Thus, three assessments were undertaken by clinical psychologists, Ms Jensen, Dr Thomson and Ms Torok, together with an assessment by a psychiatrist, Dr Judson, who has specialised experience working with intellectually disabled offenders.

[365] All four assessors canvassed J's previous diagnosis and undertook assessments of J's mental and physical health, revisiting the incident reports of J's behaviour between mid-April 2016 and May 2017. The three clinical psychologists undertook risk assessments using clinical risk management tools, including the Historical Clinical Risk – management 20 (HCR-20) and the Level of Service/Case Management Inventory (LS/CMI). All four specialist assessors concluded that J poses a high or very high risk.

J's past history

[366] Each of the assessors confirm that J's diagnosis of mild intellectual disability and autism are well established. The presentation of J's disorder has been well documented. Ms Jensen referred to Dr Duff's 2013 summary to illustrate J's disorder:

> [J], in common with most people with autism has difficulty in putting himself in someone else's shoes, seeing their perspective or understanding that the thoughts and feelings of other people might differ from his own experiences. Part of the presentation of autism for [J] involves restricted and fixated obsessional interests and a difficulty in differentiating between his "fantasy" world and the 'real' world particularly as it exists for others around him. [J's] fixated beliefs are grouped around; a desire to chop off the feet of young girls or adult women in order to sniff them, put them in his mouth or rub himself against them for sexual pleasure; a desire to act out violent scenes from action movies or cartoons such as James Bond or South Park; and interests [sic] in talking about and drawing pictures of Nazis, soldiers and weapons. [J] will

> return to these themes in conversation, in activities such as drawing and in actions whenever the opportunity presents itself. It should be noted that [J] means no harm to others as he fails to have a core understanding of the permanency of harm believing rather, for example, that his victims will get up and go home after he has cut off their feet.

[367] From each of the assessors, J's problem behaviours and risks can be briefly summarised as follows:

(a) J's autism and intellectual disability are central to his challenging behaviour and aggression.

(b) J's obsessional interests and impulsive behaviour continue to be ongoing features of J's presentation and risk profile. He remains sexually aroused by feet, especially women's feet;[226] he continues to have violent outbursts and fantasies (e.g. striking out at the walls and ceiling, biting staff (in relation to his hypersensitivity to loud noises); and was sexually inappropriate at times (e.g. touching staff in October 2014).

(c) Between mid-April 2016 and 1 September 2016, there were 36 incident reports of J's behaviours, including 18 incidents of actual or attempted property damage (such as breaking windows), five occasions of absconding and seven serious incidents of actual, attempted or threatened violence. Between November 2016 to April 2017 there were an additional 25 incident reports, including physical assaults on staff and his mother, 10 threats to harm or kill members of the public, seven occasions of property damage and four attempts to escape with the intention of causing property damage. In April and May 2017, there were a further 10 incident reports, including violent fantasies, threatened and attempted violence as well as attempted property damage, although Dr Judson noted that the degree of severity of a

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[226] Although in 2005, Ms Breen noted that J's foot fantasies often involved force, weapons and restraint, Dr Immelman, psychiatrist, in 2012 to 2014 and Ms Jensen in 2016, recorded that J remained sexually aroused by feet, especially women's feet.

number of the incidents in these two months is less and the recording and consistency of interventions has improved.[227]

(d) Particular incidents of note included J attempting to attack the driver of the van while it was travelling at 100 kilometres on the motorway because J wanted to experience being in an accident; grabbing a child's foot at a family Christmas gathering; J absconding while on a visit to the doctor and shouting at members of the public that he wanted to insert women's feet into his anus; and J taking a kitchen knife from an unlocked cupboard, which he presented to his mother and staff, stating he wanted to kill palagi people.

(e) J's behaviours, obsessions and lack of insight remained essentially unchanged over many years, despite environmental management, specific interventions and a structured individualised care programme. However, there have been some notable improvements in J's care and presentation due to a busier schedule, increased staff interaction and daily implementation of a sensory kit. J has been able to focus on tasks for longer and can be more easily redirected when he becomes fixated, agitated or draws inappropriate images.

[368] The three clinical psychologist specialist assessors adopted risk assessment tools to measure J's risk: Ms Jensen and Ms Torok used the LS/CMI, while Dr Thomson used the HCR-20 tool. From the four assessors, (including Dr Judson's assessment) J's risk assessment can be summarised as follows:

(a) J's risk of reoffending has consistently been rated as high, particularly in relation to violence.

(b) J's risk is associated with his history and ongoing incidents of aggression, threats of violence, violent fantasies, impulsive behaviour, attempts to abscond, poor engagement in vocational services at

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[227] Dr Judson noted the MADRID Risk Reporting System, which was introduced into the service on 10 April 2017, will provide a sensitive indicator of changes in the level of behavioural disturbance from day to day.

Framework Trust (although this is improving) and poor engagement with staff and his care plan. J also does not have an understanding that his violent behaviour could cause harm to any victim.

(c) Acute risk factors that increase J's risk of behaving violently include sudden noises, changes in his routine and the stress he experiences when his future is uncertain.

(d) J's risk factors are currently being successfully contained through environmental restrictions, especially ensuring no access to weapons, children or women's feet; no access to the community unsupervised; immediate intervention using a variety of strategies when J shows signs of agitation; and management of external stimuli by environmental modification. There are thus ongoing concerns about how J's risk would be managed in the absence of environmental constraints and intensive staff supervision of his behaviour (particularly from male staff).

(e) Despite the high level of care and support from staff, on some occasions, J has still been able to abscond, or access and hide a knife. It is therefore probable, that without the current level of care, J would reoffend.

(f) The assessors agreed that J's status needed to be as a secure care recipient. Any progress in reduction and management of the level of J's risk is predicted to be slow.

[369] The conclusions reached by the assessors are based on clinical reviews and interviews with J, as well as formal risk assessments, in the case of the three clinical psychologists.

[370] J challenges the validity of the risk assessment tools, because such tools are designed to assess the risk of reoffending and are not valid tools for informing a comprehensive risk assessment for those with intellectual disability and autism. I turn

then to consider the validity of the risk assessment tools used by the clinical psychologists.

The validity of the risk assessment tools

[371] Both specialist assessors, Ms Torok and Dr Judson, were questioned about the tools that were used in their recent respective risk assessments provided to the Court for this inquiry.

[372] Dr Judson had referred to the MADRID system, which was developed at the Forensic Mental Health Unit, the Mason Clinic, as a tool where individuals are scored for a number of potential risk behaviours or risk factors. However, Dr Judson did not consider that it was necessary to use any risk assessment tools, first, because he was not totally convinced that the tools have been fully reliable or validated for people like J. The tools are validated either for offender populations or for people with mental health disorders, but not for people with intellectual disability. Thus, the tools are used and adapted but are not perfect.

[373] Secondly, as a psychiatrist, Dr Judson undertakes assessments of risk, based on clinical predictions, taking into account a person's longitudinal history. Psychiatrists are not trained to do assessments with the use of the risk assessment tools, as that is the training of psychologists. Dr Judson clarified with the Court that when he undertakes assessment in psychiatric clinical practice, the assessment is a triangulation, of a longitudinal picture obtained from a pattern of behaviours or problems that have occurred in the past, a cross-sectional picture of the person on presentation at interview, and an assessment of their current status.

[374] In cross-examining Ms Torok, Dr Ellis challenged Ms Torok's use of the LS/CMI, which did not result in numbers, but a value description such as "high" or "very high", as examples. Dr Ellis also drew Ms Torok's attention to the decision of the Court of Appeal in *R v Peta*, where the Court cautioned judges against rubber-stamping health assessors' reports on the basis of mechanical and potentially formulaic assessment of risk, arising from actuarial tools.[228]

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[228] *R v Peta* [2007] NZCA 28, [2007] 2 NZLR 627 at [50]–[53].

[375] Ms Torok was aware of the *Peta* decision and drew a distinction between the actuarial tool used in *Peta* compared to the LS/CMI. In describing the LS/CMI, Ms Torok said this:

> That's not an actual tool, this is a structured professional judgement measurement. There is one factor which includes static risk factors when we discussed criminal history, previous offending, previous charges, but the rest of the risk factors addressed dynamic risk factors so these would be risk factors that can be addressed in treatment.

[376] Ms Torok also explained that there are eight risk factors to consider, when using the LS/CMI and on those risk factors, J did not present with high risk of reoffending. She described J's specific risk relating "to factors that are not included in the LS/CMI and these are the fixation on violence."

[377] Ms Torok described how J's unique risk factors led her to apply a "clinical override" when administering the LS/CMI in upgrading J's risk. In addition to describing J's fixation on violence, Ms Torok described J's lack of insight specifically in the impact of his offending on the victim; a lack of victim empathy; delayed violent retributions for former incidents, with no predictability when such violence would occur; J's agitation on hearing sudden noises; and his environmental issues such as his fixation with feet of children and females. On the criminal history factor, Ms Torok said:

> … very interestingly he rates really low but that's because he only has three charges. So he was charged on one occasion he had not appeared before the Court prior to these charges but we also know that he had presented with behaviour issues also quite serious ones that he could have been charged for. … And my understanding is that he was not charged for the assault on the girl when he was 17 years old, on the first occasion. But he continued to present with behaviours such as damaging property, accessing weapons and threatening people, and also assaulting people that he has not been charged for. So on the criminal history, I have to rate him low because formally he has not been charged.

[378] Ms Torok said further that J's behaviour was one reason why "an override" was implemented at the end of the assessment. She explained that based on the ratings, J's risk would be described as medium but he presents with risks that are not included in the LS/CMI. These include further offending behaviour that he was not charged for and issues that raised his violence risk, which include his impulsivity, his special interest in weapons, violence and his threats to kill people. These are the factors that

specifically raise his violence risk. As J continued to present with evidence of all these factors during the review period when Ms Torok saw him, J's risk was upgraded.

[379] Dr Nicol Wilson, who is an expert in the science of risk assessment in New Zealand, was called by the Care Coordinator to give evidence on the use of risk assessments. Dr Wilson referred specifically to the Court of Appeal's decision in *Peta* and the strong guidance provided by both the Court and Glazebrook J in her article, *Risky Business: Predicting Recidivism*, concerning the use of clinical risk assessment tools in legal proceedings.[229]

[380] Dr Wilson referred to two important principles emerging from judicial guidance. The first, is that risk assessment tools present with limitations and there is a need to ensure that experts place such limitations before the Court. Secondly, clinicians need to use individualised assessments, rather than relying strictly on actuarial tools. This guidance is provided specifically in *Peta*[230] and in Glazebrook J's article, where the focus on "individualised assessments" is emphasised:[231]

> In the decision-making process courts are, of course, concerned with individuals. Thus, a type of risk assessment approach that combines various risk assessment tools with a discussion of other causative (and protective) factors, such as situational and environmental concerns which relate specifically to the individual, is required. …
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> The assessment of risk must ascertain both the environmental factors surrounding the individual and the specific factors inherent to the individual that increase his or her risk of recidivism.[232] This approach ensures that dynamic factors relating to the individual are taken into account, thereby helping to avoid "the shortcomings of a mechanical and potentially formulaic assessment of risk."[233]

[381] Dr Wilson, in his brief of evidence, canvassed the evolution of risk assessment approaches over the last 30 years, which he described in generation categories:

(a) first generation risk assessments relied on professional judgment but was not particularly accurate;

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229 *Peta*, above n 228; and Glazebook, above n 186.
230 *Peta*, above n 228, at [52].
231 Glazebrook, above n 186, at 98–99.
232 *Peta*, above n 228, at [52].
233 At [52].

(b) second-generation risk assessments used actuarial, static risk scales based on variables with a proven link to crime;

(c) third-generation risk assessments also used actuarial measures of risk but with the addition of dynamic needs to static risk variables; and

(d) fourth-generation risk assessments, which integrate actuarial approaches with structured professional judgment and case management for the purposes of treatment and to change the assessed risk.

[382] Although Dr Thomson and Ms Jensen were not called as witnesses in the High Court hearing, both provided evidence in the Family Court on their use of the fourth-generation risk assessment approach. From the notes of evidence in the Family Court, which were provided to me, they described how that approach ensured their focus on J, as an individual and his particular risks and strengths. As noted above, Ms Torok also used the LS/CMI tool, which is a fourth-generation tool. However, she emphasised that it was a means of imposing a structured professional judgement measurement, not an actual tool.

[383] Ms Medlicott, in her evidence on the use of risk assessments by specialist assessors, described the current practice of using fourth-generation risk assessments. Again, the process involves the consideration of actuarial data by specialist assessors as well as environmental and contextual risk factors, leading to the likelihood, imminence and severity of a particular event occurring, which conforms with the guidance from the Court of Appeal in *Peta*.[234]

[384] Ms Medlicott described the fourth-generation risk assessment process as follows:[235]

> [71] It is the fourth-generation risk assessment process that is usually used by specialist assessors. … Information is taken from a wide variety of sources, including actuarial measures, and is combined to provide a structured risk profile. Considerations are given to areas such as an

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234 At [44].
235 Footnotes omitted.

> individual's criminal history, prosocial or antisocial attitudes, associates and peers, personality issues, family or intimate relationships, employment or education, recreation and leisure activities, substance use, mental health, housing status and general support. Information to inform the risk assessment can come from review of documentation, interview with the person concerned, interviews with family/whanau and support providers, and from observations, as well as completing (often more than one) formal assessment measure. One significant goal of fourth generation risk assessment processes is to be able to identify features that could be targeted and may be able to reduce the assessed level of risk.
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> [71.1] Many available assessment measures, such as the HCR-20v3 and the Level of Service/Case Management Inventory (LS/CMI, by Andrews and Bonta 2004), provide clear methods of gathering relevant actuarial information, as well as considering additional information to assist in the development of a broad and well considered structured risk assessment that also considers areas of strength.
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> [71.2] Many of the assessment measures used within a fourth generation process are applicable for people with intellectual disability, including the Violence Risk Appraisal Guide (Harris, Rice and Quinsey, 1993) and the STATIC-99 (Hanson and Thornton, 1999). The HCR-20 and the LS/CMI have also been found to be a good predictor of future offending for those with intellectual disability, particularly if amendments are made to take into account specific issues for people with intellectual disability.
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> [71.3] One particular fourth generation assessment measure was specifically developed for those with intellectual disability. This is the Assessment of Risk Manageability for Individuals with Developmental, Intellectual Limitations who Offend – Sexually (ARMIDILO-S) (Boer, Tough, and Haaven, 2004). This instrument has subsequently been released by the developers on the internet.

[385] Dr Wilson gave specific details of each of the HCR-20 and LS/CMI assessment tools, addressing the issue of how problems with major mental disorder, personality disorders, traumatic experience or history of problems with violent attitudes or ideation are assessed. Dr Wilson concluded that the HCR-20 is designed, not just to assess risk, but to assess how to change risk and part of changing risk is looking to the future. Similarly, in the fourth-generation LS/CMI, Dr Wilson described the change from the third-generation measure, which looked at risk and need, to a comprehensive assessment, properly attending to responsivity and how to address the person's risk factors. This may include the specific risk of the individual and their problems with

compliance, or a diagnosis of psychopathy, or inappropriate behaviour, such as specific types of violence and other forms of anti-social behaviour.

[386] I have already addressed the way in which each of the specialist assessors have identified specific individual risk factors for J. The description by Ms Torok of the clinical override in applying the LS/CMI is consistent with the Court's guidance in *Peta*, that risk assessments and the related judicial decision-making for risk management are best informed through an individualised formulation of risk. Ms Torok, during her evidence before this Court, provided the Court with her LS/CMI worksheet, which she completed in assessing J. She described how she used her "clinical override" to address the unique risk factors particular to J.

Margins of error for risk assessments

[387] J's challenge to the validity of the specialist assessors' risk assessments included the absence of reporting "error rates" or "margins of error" in risk assessment reports. In *Peta* the Court warned that the results of a properly conducted risk assessment must be effectively communicated to the Court. The Court said:[236]

> When reporting the findings of a risk assessment, comparative categorical labels such as high, moderate or low risk should be qualified by probability statements that give corresponding re-offence rates for groups of similar offenders and the numbers of offenders in each category should be specified: … Any category or label such as low, medium or high, should be used consistently in any report.

[388] Dr Wilson, in his description of the generations of risk assessments, described both in his brief of evidence and under cross-examination, that where an assessor has conducted a fourth-generation individualised assessment, the statistical error rate may not be relevant to the ultimate outcome of the assessment. He agreed that the error rates were not specifically communicated in the reports, but considered that a Judge should be able to make a decision on the reliability of the risk assessment.

> Whether that's done through talking about the statistical error or whether it's done through discussing the individual and the frequen[cy] of behaviour for the individual and that allows also the trier of fact to make their mind up about the risk.

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236 *Peta*, above n 228, at [53].

[389] Dr Wilson also explained the importance of whether the assessment is comprehensive, as it is less likely that error will be present, when the assessor is looking at all the factors. He said:

> Now the more comprehensive assessment is the more multi-determined it is, the less likely that error will be present because you are covering off. That's why you need to look at the strengths and protective factors. You need to look at how risk is supported from multiple different items. That's where you also start to manage the limitations as well as convey them.

[390] When pressed further under cross-examination as to the error rate of the assessors' reports and their ultimate reliability, Dr Wilson reinforced that with the HCR-20 and the LS/CMI, the key information is not just that the person is "very high risk" or "high risk", but what the person is at risk of doing and under what circumstances. He said:

> The degree of error of the opinion is difficult to establish. However, research with the HCR-20, which relies on a professional judgment at the very end, so … it's guided by the items that it relies on, has been found to have overall accuracy of around 70%. So it's not without accuracy, but it's also not without error. … you've got an approximately 30% error over a group … your error may be less for some people and greater for others, but it's more than just flipping a coin or blind, ill-informed judgment. It has a degree of accuracy. So I think one of the key pieces of information that the Judge needs to know for the HCR-20, and I also believe for the LS/CMI, is not just that they're very high risk or high risk, but what they [are] at risk of doing, under what circumstances, because that's part of the Judge being able to establish the veracity of it, and know whether those limitations have been addressed.

[391] Dr Wilson agreed that the application of the risk assessment tools to persons like J has been limited in part, because so few people with autism and intellectual disability actually offend. Thus, very few of them have the presence of the risk factors that J presents. He concluded that "at the end of the assessment, it is a professional judgement and while it's guided, it is not a technician approach, it is a clinician approach."

Conclusion on risk assessments

[392] The risk assessments of J undertaken by the three clinical psychologists within the space of 12 months, before this inquiry, all concluded that J poses a high or very high risk of future violent behaviour. Each clinician has applied risk assessment tools, which on the evidence before me, are best-practice, fourth-generation assessments,

which have been individualised to J's specific risks and strengths. The likely risk scenarios have been clearly expressed, and as Ms Medlicott opined, the assessors were able to provide information about historical events, as well as the more recent events, and the reason why these are occurring. She concluded that the assessors have completed good risk formulations and their views that J is highly likely to repeat such offending without external controls were reasonable.

[393] Each of the recent assessors has been subject to cross-examination, as has Dr Thomson and Ms Jensen in the Family Court. Although there is a margin of error with any assessment, for reasons which are addressed below, I do not consider the error margins invalidate the assessors' risk assessments.

[394] All four risk assessments, from Dr Judson and the three clinical psychologists, involved professional clinical judgement, based on substantial clinical experience. The assessments provided valuable guidance to the Court and I do not uphold the challenge to their validity.

Any reduction of risk by rehabilitation?

[395] Rehabilitation is an important objective of the IDCCR Act. The Court of Appeal in *RIDCA* recommended that when making an extension decision, the Judge should be informed of the rehabilitation efforts that have been made, the outcome of them and be advised of the prospects of future rehabilitation.[237] The Court said:[238]

> If the risk posed by the care recipient is unlikely to be reduced through rehabilitative efforts, the Judge may take that into account in determining whether the community protection interest continues to be outweighed by the liberty interest of the care recipient.

[396] In her specialist assessors' review, Ms Torok confirmed the concerns expressed by J's mother and Dr Webb, that J was becoming isolated and experiencing deterioration in his quality of life, because of his limited access to the community. Because of J's high risk of violence, staff were becoming more risk adverse and J's

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237 *RIDCA*, above n 64.
238 At [92(b)].

scheduled outings were often cancelled, due to J's behavioural incidents or technical issues, such as shortage of staff or no access to a vehicle.

[397] Dr Webb described the recent audit report on the facility, TRT, where J was being accommodated. It was critical of the level of care delivered, the level of reporting inactivity, the lack of focus on J's autism, and that directed rehabilitative programmes had not been implemented. Rehabilitative programmes were put in place for J, approximately six months before this hearing and during that time, Ms Torok confirmed J's community access had been extended. He has a weekly activity plan including sensory modulation, visits to his mother's house, attending Framework Trust, gardening with his mother at the care facility, and guitar lessons or sports at a local community centre. These activities have provided J with more opportunities for social interactions and since January 2017, started to join care recipients of the neighbouring TRT care facility, for dinner one night a week.

[398] J has been seen weekly by his IDOLS treatment team from the Mason Clinic. As a result of staff training in sensory modulation, there has been positive feedback by J, his mother and care staff. J has been easier to redirect and quicker to calm down. This has been attributed to the increased use of the sensory kit with J and his increased access to activities. Communication has improved among those who are involved in J's care, including NIDCA, TRT, Framework Trust and IDOLS, to discuss barriers and solutions to implementing J's plan. Communication with J's mother has been improved, with greater information provided to her on incidents relating to J and consultation with her about any changes in his plans. Ms Old from the Justice Action Group reported that there have been notable changes in J's care.

[399] Ms Daysh is the manager of NIDCA and has held that role since 2013. She gave evidence for the Care Coordinator and among other issues, addressed rehabilitation, being one of the purposes under the IDCCR Act. Although "rehabilitation" is not defined in the Act, NIDCA understands it to mean "improvement of the character, skills and behaviour of an offender through training, counselling, education etc in order to aid reintegration into society". Because persons with intellectual disability can often learn how to better manage their impulses and

regulate their dysregulated behaviours, a period of compulsory care and rehabilitation may improve their functioning to a point where compulsory care is no longer required.

[400] Ms Daysh described the period of time J resided at the Mason Clinic where, as a result of a consistently implemented behaviour management plan, J was transitioned back to a community secure care facility managed by TRT on 17 May 2011, due to the reduction in the frequency and severity of incidents involving J.

[401] In September 2011, J's compulsory care order was varied to supervised care, in the mistaken belief that supervised care would allow greater flexibility in arranging community outings, particularly visits to his mother.[239] As it transpires, such a change was not necessary to facilitate these visits. This change in status was intended to assist with planning for J to eventually transition from a compulsory care order to a less restrictive placement. However, due to his ongoing risk, J continued to reside in a community facility but was subject to many of the same restrictions required for secure care, in order to manage his risk. Following the recommendation of the specialist assessors in the Family Court, J's order was extended for 18 months and varied to a secure order.

[402] J currently lives in Motuhake Whare, a secure community facility managed by TRT.[240] J lives in the Whare with two full time live-in staff and when he leaves the Whare for a community outing, he is accompanied by three staff. The Whare has a high perimeter fence and locked gate. It has been modified to J's needs. For example, it has soft closing doors and double-glazed windows to avoid J being exposed to loud noises. The windows of the Whare are frosted to avoid J being able to see people on the street. Loud noises have a tendency to set off J's behavioural problems and the frosted windows are to deal with J's obsessional interest in pākehā women and feet. The walls are also reinforced to minimise property damage and sharp objects, such as knives, are kept in a locked cupboard. As Ms Torok described, IDOLS from the Mason Clinic developed an individual behaviour management plan for J, based on a functional analysis of J's behaviour.

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239 At [466] of this judgment also.

240 TRT is a Kaupapa Maori Service that supports people of all ethnicities with intellectual disabilities.

[403] Due to the changes in J's care and the rehabilitative efforts made, Dr Judson observed that there has been some pleasing progress in J's behaviour and in the range of activities available to him over the previous months. Less intrusive intervention on the part of staff is being required in order to redirect and manage J's thoughts and behaviours. Despite this, Dr Judson concluded:

> However, [J] still requires a very high level of vigilance and the constant presence of male staff, together with a secure environment. Essentially the risks have not changed, but are being well managed. The current range of interventions, and the recording of behavioural and other problems, are robust and appropriate.
>
> The current order is necessary and should continue. Any progress in reduction and management of the level of risk will be slow. Whether it will be possible to reduce … the active risk to a level where it is conceivable that he would be able to live in a less secure placement is yet to be seen, and would certainly require a long time. No modifications are suggested to his current care programme at this stage.

[404] Ms Torok's conclusions, as already set out, confirm Dr Judson's opinion. Even with the change in J's care management, J's behavioural risks are still ongoing. The 34 incident forms, which Ms Torok appended to her report for detailed descriptions of incidents concerning J (which have been partly summarised at [367]) support the estimated risk of J "reoffending", which is considered to be within the high to very high range. His risk continues to be related to the specific characteristics of his autism, as Ms Torok concluded. Despite the efforts of staff and J's mother to explain the consequences of some of the incidents, J's behaviour continues to occur. One of those incidents involved J attempting to break his mother's finger.

[405] Although events in the last year have shown J's risk may be reduced by rehabilitation, he continues to present a significant and ongoing risk to the community.

(b) J's liberty interests

The relevance of the index offending

[406] In considering J's liberty interest, I must bear in mind that J's liberty interest is not necessarily static and because J has been subject to a compulsory care order for

more than 12 years, I may determine that greater weight needs to be given to his liberty interest, as the Court of Appeal recommended.[241]

[407] In considering J's liberty interest there are two issues in particular to be considered:

(a) the relevance of J's "index offending"; and

(b) the lowest level of compulsory care required to achieve community protection.

The relevance of J's "index offending"

[408] Although J's index offences were charges of being unlawfully in a yard and wilful damage, there have been numerous incidents, both prior to becoming a care recipient and following, which could have resulted in further criminal charges. For completeness I set them out. They are:

2000 – aged 16 years	J injured a female student by cutting her neck at school requiring hospital treatment.
2003 – aged 19 years	J attempted to kiss a student and became angry when he was pushed away, requiring staff intervention.
2004 – aged 20 years	J was picked up by the police at his school in the early hours of the morning, after he smashed windows and stole photographs of teachers, stating he was James Bond on a mission to cut teachers heads off.
2006 – aged 22 years	J charged with unlawfully in a yard and wilful damage.
2012 – aged 28 years	J attempted to climb out of a van to touch strangers and broke free from care staff in a park to touch a female's feet. J injured his mother's fingers and punched his Justice Action Group advocate in the face for not being allowed to live with his mother.
2014 – aged 30 years	J attacked the driver of his van while it was travelling on the motorway. J grabbed a child's foot at a family Christmas event. J absconded from a doctor's visit and shouted at members of the public that he wanted to insert women's feet into his anus.

[241] *RIDCA*, above n 64, at [92(f)].

2015 – aged 31 years	J grabbed the foot of the CEO of TRT, took off her shoe and began sniffing and licking her foot. Four staff intervened and removed him from the room.
2016 – aged 32 years	J threatened to cut the throat of a female team leader at Framework Trust and threatened a female Care Manager. This resulted in a new male Care Manager being appointed. J drew pictures about how he would cut the neck of Trish Noble, the manager of Solway Trust. He also talked about wanting to burn a house down in Henderson.

[409] The numerous other incidents recorded in special incident reports, referred to by Ms Torok and Dr Judson in the most recent assessments, also contain incidents that may well have resulted in criminal charges, but for J's disability.

[410] Clearly, J has been subject to a compulsory care order for a much longer period than the likely length of time he would have been sentenced for the index offending. As the Court in *RIDCA* cautioned, a compulsory care order must not be disproportionate to the need to protect the community or the care recipient.[242] The Court further concluded that whilst the nature of the original offending may provide an indicator of the level of risk posed by the care recipient, the Court also envisaged a case where a care recipient, who committed a minor offence, could constitute a very significant and ongoing risk to the public. In such a case, the Court said:[243]

> the community protection interest will overwhelm the liberty interest, and the assumption must be that the minor nature of the offending did not provide an accurate guide to the level of risk posed by the care recipient.

[411] In J's case, I am satisfied that the nature of this index offending does not provide an accurate guide to the level of risk posed by J. This issue was addressed head-on by Ms Torok, when she reported that issues related to proportionality were considered and it was concluded that due to J's high risk, the community protection interest outweighed the liberty rights of J, resulting in repeated extensions of the care order. Even though J was subject to a supervised care order between September 2011 and October 2016, in reality, J received a secure level of care in terms of environmental constraints, management and staffing levels.

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242 *RIDCA*, above n 64, at [59].
243 At [94].

[412] I bear in mind, that proportionality to the index offence is but one consideration, particularly as the IDCCR Act is protective and rehabilitative, not punitive. I am satisfied that the minor nature of J's index offending does not provide an accurate guide to the level of risk posed by J.

Lowest level of compulsory care required to achieve community protection

[413] The final consideration is whether there are other less restrictive options to J being subject to a compulsory care order. In the overall balancing exercise, the compulsory care order must not be disproportionate to the need to protect the community and should be the lowest level of compulsory care achievable.

[414] On this issue, the specialist assessors and Ms Daysh from NIDCA have considered J's express wish to return to his mother's home. As Ms Torok notes, J's mother, with the support of Justice Action Group, has been working towards the same goal. J's mother planned to achieve this by securing funding for an individual package of care that would provide a long-term service in the family home. This was also urged by J's counsel and indeed, J wrote to me expressly, asking that he be released to his "number one" home. Dr Webb envisaged that, with the continuation of the rehabilitative care programme, J could be released to Solway under the high and complex needs service, where J, who has very high needs, can be appropriately supported without being detained under the Act.

[415] As will be evident from the specialist assessors' reports, Dr Webb's view was not supported. Dr Judson gave evidence of the need for the established patterns of J's risk behaviours to abate, before J could be transitioned from secure care to a mainstream service.[244] Dr Judson referred to J's established patterns of risk behaviours, which have been seen consistently over a long period of time and "which haven't actually changed very much over time, except in as much as there is an intervention to nip those behaviours in the bud before they start, before they actually get out of hand and anybody gets hurt."

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[244] Mainstream services are service providers in the community, supported by intellectual disability services.

[416] When asked how J's risks might be reduced and how long that process might take, Dr Judson said:

> The problem is that these behaviours are not arising from an easily treatable disorder. If you had somebody, for example, who had a mental illness like schizophrenia and those behaviours were only seen when the person was psychotic, it's nice and simple, you treat the psychosis … It's very difficult for somebody like J, who has an ongoing disability and an ongoing disorder like autistic disorder, which is actually not treatable, it's manageable but it's not treatable, which means you can't change the underlying condition but you can put steps in place to manage the effects of that. So the trajectory that has been seen with J over the years, as I understand it, is that since he was an adolescent there has been a pattern of behaviour that has emerged that, in essence, has not changed over time. It's been managed by staff and environmental interventions that ensure that those behaviours don't become too intense and don't get out of hand and to try and minimise the kind of circumstances in which they are likely to occur. I don't think we are actually seeing a lot of change otherwise.

[417] On further examination, Dr Judson compared J and the level of his needs with other persons with intellectual disability and told the Court that if J was living in the Wellington Region, he would certainly be within a secure hospital unit, such as the Forensic Unit at Porirua, as there is no facility that would provide the level of environmental security and intense staffing, that is provided at J's accommodation at TRT.

[418] When asked whether J is at a stage that he could be moved from a secure level or supervised level compulsory care order to mainstream services, Dr Judson was adamant J was not at that stage. In his view, J could not be in a service where there was no compulsion engaged and no staff to prevent J from carrying out his fantasies and ultimately injuring others or himself. In the facility in which J is currently accommodated, which is the next level down from hospital level secure facilities, the staff are always "alert and very conscious of the fact that [J] could try and do something inappropriate at any minute".

[419] For all of those reasons, Dr Judson believed that the current order is necessary, because it would not be realistic to allow J to make his own choices or release him from under tight control, "given the level of close calls" and the "number of worrying behaviours", which still occur from time to time. He considered the level of control currently in place was still needed.

[420] Dr Judson had also given consideration to whether J might have a mental disorder under the MHCAT Act. Dr Judson considered that J had a disorder of cognition and a disorder of volition. His unusual thought patterns represent a disorder of cognition and the impulses to do some harmful behaviours and act them out could constitute "potentially a disorder of volition". Dr Judson considered that such a diagnosis would not be helpful for J, because under the MHCAT Act, J could not be detained in a community based facility but would have to go to a secure psychiatric unit, which is more disadvantageous to J.

[421] Ms Daysh also confirmed that if J were moved to mainstream intellectual disability services, i.e. service providers in the community such as Solway Trust, those providers would not be able to provide an adequate level of care to J. J's complex needs and his violent ideations require care within the high and complex framework, which involves residential care in a RIDSAS facility, as J presently has. The compulsory care order is required, to require J to reside in such a facility to ensure that his needs and behaviours are adequately addressed.

[422] The evidence from Ms Daysh reinforces the longitudinal history, that has been collated over the years when J has been a care recipient. This history has been considered and referred to by each of the specialist assessors, in reaching their view about J's risk.

[423] From all the evidence I have heard, including all the specialist assessors' reports and the evidence adduced before the Family Court in 2017, I am satisfied that the community protection interest continues to be outweighed by J's liberty interest. This is not, as the Court in *Peta* warns, a "rubber-stamping" of the specialist assessors' reports but a view I have reached on the totality of the evidence, which in J's case, is overwhelming.[245]

[424] I have given consideration to whether the risk posed by J could be reduced through rehabilitative efforts and for the reasons I have addressed above, I accept the evidence of the experts, and in particular Dr Judson's evidence, that any progress in

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245 *Peta*, above n 228.

reduction and management of the level of risk will be slow.[246] For the future, clearly all specialist assessors and care providers should be alert to the possibility of reducing J's active risk to a level where it is conceivable, that J may be able to live in a less secure placement. However, I accept Dr Judson's evidence, that that is yet to be seen and will require a long time.

[425] As a result of the Family Court review in February 2017, attention has been drawn to the need for a better rehabilitative focus in J's care, by addressing his autism and associated behaviours. Steps had also been taken to improve communication and consultation with J's mother, who felt she was unheard and overlooked, when she raised her concerns about J's care. The recent efforts made to address J's care and rehabilitation are to be commended and should continue, as should the involvement and consultation with J's mother, who has her son's interests at heart.

[426] I have given careful consideration to J's liberty interest and accept that it should not be assessed as static. Although J has been detained under a compulsory care order since 2006, the fact that J's risks have not changed, even though they are being well managed, does not give greater weight to J's liberty interest at the present time.

[427] I have taken into account the nature of the original offending, yet for the reasons I have addressed above, consider that even though J will remain subject to a compulsory care order, well in excess of a sentence for the index offending, the minor nature of the offending does not provide an accurate guide to the level of risk posed by J.[247] J constitutes a very significant and ongoing risk to the public, even though the index offending was for minor offences. The incidents which occurred prior to J being charged with the index offending and after he was made a care recipient, reinforce that the index offending does not reflect J's ongoing risk.

[428] I consider therefore, that J's status as a care recipient under a compulsory care order at a secure level of care is not disproportionate to the need to protect the community and he needs to continue to be cared for as a care recipient at a secure level of care.

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246 At [403] of this judgment.
247 At [411] of this judgment.

Conclusion

[429] I am satisfied that J is not detained illegally as a care recipient, as J has an intellectual disability. I am further satisfied that J needs to be cared for as a care recipient, under a compulsory care order at a secure level of care, because J presents a significant and ongoing risk to the public.

PART 4 – JUDICIAL REVIEW PROCEEDINGS

[430] J sought judicial review on thirteen grounds. Following the hearing of the three previous proceedings, the two appeals and the s 102 inquiry, Dr Ellis amended the pleadings to eight grounds of review and confined his submissions to three principal grounds, namely:

(a) arbitrary detention;

(b) discrimination; and

(c) errors of law.

[431] J seeks declarations by way of relief in each of the above grounds. There are four further review grounds, which comprise alleged breaches of NZBORA, stay of proceedings and compensation. An additional ground was pleaded in the amended statement of claim, that the District Court unlawfully destroyed J's criminal file, for which J seeks declarations, compensation and punitive damages.

New Zealand's disability legislation

[432] Before addressing the grounds of review, it is important to place the relevant New Zealand disability legislation in context.

[433] Prior to 2004, courts were given discrete powers to deal with persons who were charged with imprisonable criminal offending and were "under disability". A person was "under disability" under s 108 of the CJA if, because of the extent to which that person was "mentally disordered", that person was unable:

(a) to plead; or

(b) to understand the nature or purpose of the proceedings; or

(c) to communicate adequately with counsel for the purposes of conducting a defence.

[434] "Mentally disordered", both under the Mental Health Act 1969 and under s 2(1) of the MHCAT Act, excluded people with an intellectual disability, unless they also had a mental disorder. The Court of Appeal in *RIDCA* reviewed the legislative

context for the IDCCR Act, referring to the commentary to the Intellectual Disability (Compulsory Care) Bill as reported back to the House from the Health Select Committee. The commentary addresses the exclusion of people with intellectual disability under the MHCAT Act as follows:[248]

> The specific exclusion of people with intellectual disability creates a legislative gap, resulting in limited options being available to the courts for dealing with people with an intellectual disability who are in need of compulsory care. For some this has resulted in inappropriate placement in prison, mental health services or discharge into the community. This bill was designed to bridge the legislative gap.

[435] The Court of Appeal in *RIDCA* observed that this legislative gap had also been identified by the courts.[249] The Court observed that when the Bill was introduced, it provided for compulsory care for intellectually disabled people, whether they were offenders or non-offenders. Subsequently, the Health Select Committee, recommended that provisions dealing with non-offenders be removed from the legislation and that subsequently occurred. The Health Select Committee also recommended that the role of rehabilitation and the care of intellectually disabled persons, subject to compulsory care, should be recognised and for that reason the word "rehabilitation" was added to the title of the IDCCR Act.[250]

[436] This provides an important distinction between the IDCCR Act and the MHCAT Act, that persons can only become care recipients under the IDCCR Act through the criminal justice system. At the select committee stage, the civil entry pathway to the IDCCR Act was removed.

[437] The pathway into the IDCCR Act framework for J was, (as canvassed in the previous parts to this judgment,) through the CPMIP Act, when he appeared in Court, charged with the index offending. Having been found unfit to stand trial, J could not be subject to a sentence, but became subject to a compulsory care order under s 25(1)(b) of the CPMIP Act, that J be cared for as a care recipient under the IDCCR Act.

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248 *RIDCA*, above n 64, at [18], citing Intellectual Disability (Compulsory Care) Bill 1999 (329–1) (explanatory note).

249 At [19], citing *R v Arama* (1993) 10 CRNZ 592 (CA) at 593–594. The Court notes that in that case, the lack of options lead to the imprisonment of the intellectually disabled accused.

250 At [19].

Arbitrary detention

[438] Under the first ground of review, J claims that his detention, by way of the compulsory care orders ordered by the District Court since 8 February 2006, was arbitrary. Further, J challenges the 2017 order by Judge Goodwin, extending J's compulsory care order and varying it from supervised to secure care. J also claims that his continued detention is arbitrary, because J has never been properly convicted, the lengths of duration the orders are not reasoned, the variation to secure care was arbitrary and J has been detained because of his alleged intellectual disability, which is discriminatory.

[439] Dr Ellis contends that J's detention is a form of preventive detention "by stealth", without the necessary safeguards and that ss 9 and 14 of the CPMIP Act and s 85 of the IDCCR Act are inconsistent with the right to be free from arbitrary detention. A declaration is sought to this effect, in relation to all the decisions made to detain J.

[440] The Crown and the Care Coordinator submit J has been detained in accordance with the law since 2006 and there have not been any breaches under the NZBORA. They argue ss 9 and 14 of the CPMIP Act and s 85 of the IDCCR Act are consistent with the right to be free from arbitrary detention and further, any detention imposed under those sections is authorised by law.

The legal principles on arbitrary detention

[441] The right to be free from arbitrary detention is codified in s 22 of the NZBORA. In *Neilsen v Attorney-General*, the Court of Appeal provided general guidance on when detention is arbitrary:[251]

> Whether an arrest or detention is arbitrary turns on the nature and extent of any departure from the substantive and procedural standards involved. An arrest or detention is arbitrary if it is capricious, unreasoned, without reasonable cause: if it is made without reference to an adequate determining principle or without following proper procedures.

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[251] *Neilsen v Attorney-General* [2001] 3 NZLR 433 (CA) at [34].

[442] In *Zaoui v Attorney-General* the Court of Appeal also suggested that a lawful detention may become arbitrary when the detention is no longer justifiable, in the sense that it has become inappropriate, unpredictable or disproportionate.[252]

[443] More recently, the Court of Appeal considered s 22 of the NZBORA in relation to preventive detention in the criminal context in *Miller v New Zealand Parole Board*.[253] In that case, the Court held the parole legislation was not inconsistent with the right in s 22 of the NZBORA or New Zealand's international obligations. The courts must act in a way which accords with the statutory framework laid out. The Court stated:[254]

> In practical terms, this means that a detention is not arbitrary where it was in accord with the sentence imposed by the sentencing judge and the required public safety assessments had been carried out by the Parole Board in a way which accords with the parole legislation.

[444] The New Zealand courts have found that detention may be arbitrary in the following situations:

(a) Unlawful detention is almost always arbitrary.[255]

(b) The purpose of the detention was legitimate, but important procedural safeguards were not observed.[256]

(c) There is no clear line between a procedural failing that makes detention arbitrary and one that does not.[257]

(d) The detention was lawful to begin with, but then became arbitrary because:

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252 *Zaoui v Attorney-General* [2005] 1 NZLR 577 (CA) at [100] per McGrath J (majority) and [175] per Hammond J (dissenting).

253 *Miller v New Zealand Parole Board* [2010] NZCA 600. As Dr Ellis has noted, this case has subsequently been subject to a decision of the United Nations Human Rights Committee, see [455] of this judgment.

254 At [70].

255 *Neilsen*, above n 251, at [34].

256 *Johnston v Police* (1995) 2 HRNZ 291 (HC).

257 *Sestan v Auckland District Health Board* [2017] 1 NZLR 767 (CA) at [44]–[55].

(i) the purpose of detention did not justify the length of detention;[258] or

(ii) the purpose of detention was unable to be fulfilled so that the detention became indefinite or permanent.[259]

International obligations and decisions

[445] Article 9 of the International Covenant on Civil and Political Rights (ICCPR) provides for the right to liberty and security of the person and, of relevance, provides:[260]

> 1. Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law.

[446] Dr Ellis relies on a number of cases from the United Nations Human Rights Committee as relevant to determining whether J's detention is arbitrary.

[447] In *Rameka v New Zealand*, a minority of the Human Rights Committee considered detention based solely on an assessment of potential future dangerousness was arbitrary and that preventive detention based on these assessments violated the ICCPR.[261] However, a majority of the Committee disagreed and held that the compulsory annual reviews by the independent Parole Board, along with the ability to judicially review those decisions in the High Court and Court of Appeal, provided ample opportunity for any continued detention to be justified and examined. The majority did not view detention in these circumstances as arbitrary under art 9 of the ICCPR.

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258 *R v Chadderton* [2014] NZCA 528 at [41(b)]; and *Zaoui*, above n 252, at [97]–[100].

259 *Zaoui*, above n 252, at [88].

260 International Covenant on Civil and Political Rights 999 UNTS 171 (opened for signature 16 December 1966, entered into force 23 March 1976), art 9(1).

261 Human Rights Committee *Views Communication No. 1090/2002 (Rameka v New Zealand)* LXXIX CCPR/C/79/D/1090/2002 (15 December 2003) at 19.

[448] In *Fardon v Australia*, the Committee considered the Australian preventive detention regime was incompatible with the ICCPR.[262] This regime allowed for serious sex offenders to be subject to continuation orders, requiring continued detention, which the Australian government claimed as rehabilitative not punitive orders. The Committee commented:

> 7.3 The Committee observes that Article 9 paragraph 1 of the Covenant recognises for everyone the right to liberty and the security of his person and that no-one may be subjected to arbitrary arrest or detention. The Article, however, provides for certain permissible limitations on this right, by way of detention, where the grounds and the procedures for doing so are established by law. Such limitations are indeed permissible and exist in most countries in laws which have for object, for example, immigration control or the institutionalised care of persons suffering from mental illness or other conditions harmful to themselves or society. However, limitations as part of, or consequent upon, punishment for criminal offences may give rise to particular difficulties. In the view of the Committee, in these cases, the formal prescription of the grounds and procedures in a law which is envisaged to render these limitations permissible is not sufficient if the grounds and the procedures so prescribed are themselves either arbitrary or unreasonably or unnecessarily destructive of the right itself.

[449] The Committee opined that the Australian regime was arbitrary for several reasons:

(a) the applicant continued to be detained after serving his term of imprisonment;

(b) the sentence was penal in character and was applied retrospectively;

(c) the procedure was civil, not criminal, in nature and consequently lacked robustness; and

(d) the Government had not demonstrated that the aim of public safety could not be achieved with a less restrictive measure.

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[262] Human Rights Committee *Views Communication No. 1629/2007 (Fardon v Australia)* XCVIII CCPR/C/98/D/1629/2007 (10 May 2010).

[450] In relation to the latter of these reasons, the Committee considered that detention on the basis of perceived danger to the community was insufficient grounds to continue the detention, commenting:[263]

> The concept of feared or predicted dangerousness to the community applicable in the case of past offenders is inherently problematic. It is essentially based on opinion as distinct from factual evidence, even if that evidence consists in the opinion of psychiatric experts. But psychiatry is not an exact science. The DPSOA, on the one hand, requires the Court to have regard to the opinion of psychiatric experts on future dangerousness but, on the other hand, requires the Court to make a finding of fact of dangerousness. While Courts are free to accept or reject expert opinion and are required to consider all other available relevant evidence, the reality is that the Courts must make a finding of fact on the suspected future behaviour of a past offender which may or may not materialise. To avoid arbitrariness, in these circumstances, the State Party should have demonstrated that the author's rehabilitation could not have been achieved by means less intrusive than continued imprisonment or even detention, particularly as the State Party had a continuing obligation under Article 10 paragraph 3 of the Covenant to adopt meaningful measures for the reformation, if indeed it was needed, of the author throughout the 14 years during which he was in prison.

[451] Dr Ellis relies on *Fardon*, and the above statement in particular, to submit that it was arbitrary for J to be moved from supervised to secure care and the lack of adequate rehabilitation support given to J, prior to November 2016, further indicates his detention has been arbitrary.

[452] In *A v New Zealand*, the United Nations Working Group on Arbitrary Detention considered that a preventive detainee who had an intellectual disability had been arbitrarily detained.[264] Mr A was sentenced to preventive detention following conviction of unlawful sexual connection with a minor. The Working Group agreed that Mr A should not be detained in prison with no plan for integration or rehabilitation, as he should receive psychological and rehabilitative care. The Working Group was critical of the decision to keep him in prison on the basis of a "suspicion that he might reoffend and for the protection of the public, a decision that is punitive, while less restrictive and more humane alternatives to prison are available."[265]

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263 At [7.4(4)].

264 Working Group on Arbitrary Detention *No. 21/2015 (New Zealand)* LXXII A/HRC/WGAD/2015/21 (5 August 2015).

265 At [23].

[453] The Working Group remarked that additional detention, in order to not be arbitrary, must be "justified by compelling reasons arising from the gravity of the crimes committed and the likelihood of committing similar crimes in the future."[266] Detention should only be used as a last resort and the Working Group noted that regular periodic reviews by an independent body must be assured to determine whether continued detention is justified.

[454] The Working Group identified concerns that the conditions for convicted prisoners serving a punitive sentence were no different to Mr A's conditions of continued detention. Mr A's rehabilitation and reintegration were not the purpose of this detention. The Working Group opined that the continuation of Mr A's detention for the protection of the public was an arbitrary deprivation of his liberty.

[455] On 15 March 2018, Dr Ellis filed a memorandum drawing the Court's attention to the recent decision of the Human Rights Committee in *Miller v New Zealand*.[267] The Committee opined that the conditions, the lack of rehabilitation and the protracted length of time that two prisoners had been detained while serving sentences of preventive detention, violated the ICCPR. The Committee considered the review mechanisms in place were insufficient.

Discussion

[456] In order to succeed under this ground of review, the court must be satisfied that J's detention is capricious, unreasoned, without reasonable cause and made without reference to adequate determining principle or without following proper procedures.[268] As the cases have emphasised, a detention may become arbitrary where it is no longer justifiable, if it has become inappropriate, unpredictable or disproportionate.

[457] The CPMIP Act and the IDCCR Act came into force on 1 September 2004,[269] just under three months after J's first appearance in the District Court on the three

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266 At [25].

267 Human Rights Committee *Views: Communication No 2502/2014* (*Miller v New Zealand*) CXXI CCPR/C/121/D/2502/2014 (21 November 2017).

268 *Neilsen*, above n 251, at [39].

269 Criminal Procedure (Mentally Impaired Persons) Act Commencement Order 2004, cl 2; and Intellectual Disability (Compulsory Care and Rehabilitation) Act Commencement Order 2004, cl 2(2).

initial charges, and prior to the s 9 hearing before Judge Epati in 2005, and Judge Kerr's disposition hearing in February 2006. I have already found, that J's detention as a result of the CPMIP Act process was lawful and the steps undertaken by the District Court Judges, were those required by the CPMIP Act, namely the s 9 "involvement hearing" and the s 14 "unfit to stand trial" hearing.[270]

[458] I have noted that the full reasons were not recorded on the court file, but it is clear, from the references on the record that Judge Epati was satisfied that J had been involved in the offending under s 9 CPMIP Act and, from the reports provided to the Court, was found unfit to stand trial under s 14 CPMIP Act.

[459] Judge Kerr satisfied himself before he embarked on a ss 24 and 25 consideration of J's disposition, that the steps under ss 9 and 14 were met.

[460] J's disposition under the CPMIP Act, to the IDCCR Act by way of s 25(1)(b) of the CPMIP Act, was lawful and justified. The reports provided to the Court on J's intellectual disability were thorough and appropriate, as the subsequent specialist assessors and the experts in the s 102 inquiry before me, have testified.

[461] J's detention therefore was not arbitrary, but justified by a lawful District Court order in 2006 and subsequently, as a result of further reviews by the District Court, on the basis of specialist assessors' evidence. The orders are not capricious or made without reasonable cause and the reasons for J's detention have been carefully delineated in the specialist assessors' reports, from Ms Breen's reports in 2005 to the most recent reports and evidence of Ms Jensen, Dr Wilson, Ms Torok and Dr Judson.

[462] J seeks declarations by way of relief that ss 9 and 14 of the CPMIP Act are inconsistent with ss 22, 25(a), 26(1) and (2) and 27 of the NZBORA. For reasons which will be addressed below, J's detention, imposed under ss 9 and 14 of the CPMIP Act and s 85 of the IDCCR Act, is consistent with the s 22 NZBORA right to be free of arbitrary detention. J's detention was imposed under those sections, as authorised by law.

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[270] See CPMIP appeal under Part 1 of this judgment.

[463] As previously explained,[271] the CPMIP Act and IDCCR Act were enacted to ensure that persons with intellectual disability were not sent to serve a term of imprisonment inappropriately. Detention imposed by those sections is also authorised by law and is not arbitrary.

The 2011 variation of J's order

[464] In the background facts pleaded in J's amended statement of claim, J submits he was treated as being detained in secure care without the court's authority, when his compulsory care order was for supervised care. Although the Court was not addressed on this pleading, it forms part of the claims of arbitrary detention and cruel, degrading or disproportionately severe punishment in breach of s 9 of the NZBORA.

[465] The facts as pleaded appear to relate to the variation of J's order in December 2011 to supervised care. In Ms Jensen's specialist assessor's report, she reported that although J's status was a supervised care recipient, he was being managed as a secure care recipient. She described J as living alone with full time two to one staff in a secure house with a high perimeter fence and locked gate. When J went out into the community, the staff ratio increased to be three to one. Following a discussion about J's care with the care team, Ms Jensen recorded that J's supervised status implied:

> a lower level of risk and also that the care plan had some flexibility which is not the case given the high level of environmental containment and supervision required. It was also the opinion of those present [J's care team] that a variation to secure would not lead to any operational changes or limit the current care plan.

[466] The Crown and the Care Coordinator submit that the change in J's status from secure to supervised care was sought to facilitate contact with J's mother outside the residential care setting. The variation order from secure to supervised care made in December 2011 was undertaken to assist J and the variation was sought, mistakenly, to provide a legal basis for granting J leave for home visits. As it transpires, such a change was not necessary to facilitate these visits.

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[271] At [433]–[437].

[467] Dr Ellis submits that J's treatment as a secure care recipient prior to the Family Court variation in February 2017, together with the poor quality of rehabilitation provided prior to November 2016, support the proposition of arbitrariness.

[468] Dealing with the unauthorised secure care submission, I do not accept that J's management as a secure recipient between 2011 and 2017 was arbitrary detention and nor do I accept that such treatment was arbitrary.

[469] There were lawful orders after each of the Family Court reviews, to detain J, which have subsisted throughout. The applicant's detention is not rendered arbitrary because the conditions of his detention were amended. In *Bennett v Superintendent Rimutaka Prison*, the Court of Appeal held that a change to the conditions in which an inmate is being detained, either by segregation, reclassification or transfer to another institution, does not create a new detention.[272] Even if an inmate is unlawfully treated while detained, the detention itself is not rendered unlawful. The remedy is the cessation of the unlawful element, not the cessation of the detention.

[470] In *Sestan v Auckland District Health Board*, the Court of Appeal reinforced that procedural non-compliance does not invalidate the subsequent process. There needs to be consideration of all the consequences, when protecting vulnerable people and the community.[273]

[471] Although Dr Ellis points to the fact that no changes were made to J's care or plan, prior to the variation of the care order in 2017, and says that J was already treated as a secure care recipient, this does not render J's detention invalid.

[472] The IDCCR Act provides for varying levels of security dependent on the care recipient's needs and risk. The level of security provided was to contain J's risk, as Judge Goodwin observed in his judgment.[274] Equally, the variation of J's order to supervised care in December 2011, when in effect, J was managed as a secure care recipient, does not invalidate or make J's detention arbitrary.

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272 *Bennett v Superintendent of Rimutaka Prison* [2002] 1 NZLR 616 (CA) at [62].
273 *Sestan*, above n 257, at [87]–[94].
274 *Goodwin decision*, above n 95, at [116]–[117].

[473] Nor am I able to uphold the submission that because J received poor rehabilitation prior to 2016, this supports the proposition that he was arbitrarily detained. As the authorities make clear, the conditions on which an inmate or patient is being detained do not render the detention unlawful nor create a new detention. The review hearing before Judge Goodwin addressed the adequacy of J's care and rehabilitation plan and both the specialist assessors and the District Inspector, together with Dr Webb, drew attention to the fact that the plan was not addressing J's autism. Nor did the supervised care order reflect the level of staffing and management required to deal with J's behavioural risk. The Judge reflected all those concerns by making the secure care order for a term of 18 months only, which was both appropriate and lawful.

Detention disproportionate to offending?

[474] There is one further aspect of J's claim which deserves mention. In each of these four proceedings at this hearing, the claim of arbitrary detention of mentally impaired offenders, such as J, is based on detention in compulsory care for periods of time exceeding the maximum prison sentence that could have been imposed on the original offending.

[475] As I have already canvassed under Part 3, there is a problem with equating the length of detention under compulsory care with the maximum prison sentence for index offending. Although it is a factor to be assessed in any extension of compulsory care orders, as the Court of Appeal in *RIDCA* cautioned,[275] it is but one of many factors and, as I have found, the minor nature of the index offending in J's case is not an accurate guide to J's risk. Such a comparison inappropriately equates the punishment of imprisonment with the therapeutic or protective care enacted for those with intellectual disability. This factor does not support a finding of arbitrary detention.

How then, does New Zealand compare internationally?

[476] The international cases of *Fardon* and others are useful in understanding how New Zealand's obligations under the ICCPR have been interpreted.[276] The cases

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275 *RIDCA*, above n 64, at [94].
276 *Fardon*, above n 262; *Rameka*, above n 261; *A*, above n 264; and *Miller*, above n 267.

examined demonstrate that there are limits to the right to be free from arbitrary detention, both under art 9 of the ICCPR and s 22 of the NZBORA. The cases repeatedly indicate that preventive detention schemes, where the primary purpose is a punitive one, breach this right. Yet, the cases also acknowledge that there may be instances where continued detention is justified, particularly where rehabilitation is the focus of the detention and where reviews and oversight mechanisms are in place to ensure detention takes place only for as long as it is justified. J's case is one of these.

[477] *Miller*, like *Fardon* and the other international authorities referred to by Dr Ellis, arise in a different context to J's case, namely, preventive detention where the focus of detention is punitive. J's case is distinguishable. It arises in the context of a protective rehabilitative scheme, not a punitive one and, as J's case demonstrates, the review mechanisms are frequent and effective.[277]

[478] In New Zealand, there are three specific oversight measures which have been utilised in J's case to ensure his detention is not arbitrary:

(a) legislative requirements for six monthly reviews of compulsory care orders;

(b) compulsory care orders are time-limited and individually focused; and

(c) District Inspector monitoring and oversight.

Six monthly reviews of compulsory care orders

[479] First, the comprehensive oversight mechanisms and reviews in place under the IDCCR Act ensure that J's ongoing condition and risk is monitored.[278] The IDCCR Act requires that there are six monthly reviews where a specialist assessor must produce a certificate as to whether or not the patient is fit to be released from compulsory care status.[279] This certificate must be forwarded to the care recipient, their welfare guardian and lawyer (if any) and the responsible District Inspector.[280]

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277 At [426] of this judgment.
278 These are also discussed by Ellis J in *S*, above n 10, at [79]–[115].
279 Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, ss 77 and 79.
280 Sections 80 and 81.

[480] This means J's detention must frequently be examined and justified if it is to continue. The Act also confers examination, inquiry (as undertaken in Part 3 of this judgment) and reporting powers on the High Court, which can be initiated by the application of any person or at the Court's own motion.[281]

Compulsory care orders are time-limited and individually focused

[481] Secondly, a compulsory care order must specify its term and the level of care for those subject to orders under the Act, who each must have a care and rehabilitation plan.

[482] Section 46 of the IDCCR Act requires that every compulsory order has the term specified in the order, which may not be longer than three years. If the term is to be extended, it may be extended under s 85, as happened before the Family Court in February 2017. This issue (in part) and the relevant legislation and cases has been canvassed under Part 2.[282] The authorities have found that there is not a three year total limit to the term of a compulsory care order.[283] The provisions under s 85 ensure that there must be a further assessment of the community protection interest against the care recipient's liberty interest and if, three years later from the original compulsory care order, a further extension is sought, an extension will be made if the care recipient continues to constitute a significant danger to the public and compulsory care is necessary for community protection, even if it means the care recipient remains in care for a long period.

[483] The important consideration, which the courts have articulated through this balancing exercise, is that the judicial assessment must be undertaken each time an extension order is sought. This is a protective mechanism to ensure that the extension power does not have preventive detention effect.

[484] J's detention as a care recipient has not been arbitrary. J's detention has followed a statutorily designed pattern of reviews and careful risk assessment, as evidenced by Judge Goodwin in the Family Court, who followed not only the statutory

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281 Sections 102–107.
282 At [221]–[224] of this judgment.
283 *J*, above n 3; *L v RIDCA*, above n 161; and *RIDCA*, above n 64.

procedures but applied the Court of Appeal's guiding principles when making J's extension order. The orders detaining J were made following proper procedures, and upon the appropriate application of principle. There has been nothing capricious, unreasoned or a decision made without reasonable cause, in the making of J's compulsory care orders.

[485] It is also relevant that the IDCCR Act provides for two levels of care: secure care and supervised care. Although there is no definition in the Act for those terms, on the evidence, the levels of care refer to the nature of the facility in which the care recipient is detained. Thus, under s 5 of the IDCCR Act, secure care means care given to a care recipient, who is required to stay in a secure facility, and supervised care means care given to a care recipient, who may be directed to stay in a facility or in another place.[284]

[486] Section 9 of the Act describes a "facility" as a place that is used for the purpose of providing care to persons who have an intellectual disability and a "secure facility" as having particular features that are designed to prevent persons required to stay in the facility from leaving it without authority and is operated in accordance with systems that are designed to achieve that purpose.

[487] Importantly, s 9(4) provides that in no case, can a prison be used as a facility under the IDCCR Act. In my view, this provision reinforces the whole purpose of the IDCCR Act, as being a protective and rehabilitative scheme, not punitive, and one that ensures that a care recipient is no longer subject to the criminal justice system.

[488] The implementation of a compulsory care order is focused on the needs and risks of the care recipient. The Care Coordinator of the NIDCA service directs where care recipients are to stay. Under s 63 of the IDCCR Act, a Care Coordinator designates the particular facility for a secure care recipient and under s 64 directs a care recipient under supervised care to reside in a designated facility. The Care Manager has the power to grant leave to care recipients to be absent from his or her place of residence and can grant (and cancel) leave, irrespective of whether the care

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[284] "Facility" and "secure facility" are defined in the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 9.

recipient is under secure or supervised care.[285] The Care Manager or Care Coordinator can retake and return care recipients to the facility where they reside, whether they be secure or supervised care recipients.[286]

[489] As the Care Coordinator and Care Manager submit, the above provisions in the IDCCR Act are reflective of the fact there are no hard lines between the levels of security or the levels of order under which care recipients are placed. Ms Daysh gave evidence to the Court that in practice, care recipients subject to secure care and those subject to supervised care may live in the same facility and there is nothing in the IDCCR Act to prohibit this. The important consideration is the level of care required for the individual needs of the care recipient. Thus, care recipients transition from one level of order to another, depending on the care recipient's response to the care and rehabilitation plan in place for him or her.

[490] Each care recipient must have a care and rehabilitation plan,[287] which sets out the type of supervision the care recipient requires, to avoid undue risk to the health or safety of the care recipient and others.[288] Again, six months after a care order is made or extended, the Court must review the contents of the care and rehabilitation plan.[289] On the making of a compulsory care order, the care recipient is entrusted to a Care Manager, who provides a care and rehabilitation plan, which the care recipient must accept.[290] The individualised care and rehabilitation plan is predicated on the individual care recipients needs and risks.

[491] I consider the individual focus on the care and rehabilitation of care recipients under the IDCCR Act ensures that a care recipient's detention, such as J's, is not arbitrary but undertaken in accordance with the principles and procedures under the IDCCR Act.

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285 Section 65.
286 Sections 110 and 111.
287 Sections 24–28.
288 Section 25(4).
289 Section 72–74.
290 Section 47.

District Inspector monitoring and oversight

[492] In New Zealand, District Inspectors are barristers and solicitors appointed either under the IDCCR Act or the MHCAT Act, or both.[291] They are appointed to ensure that the provisions of these Acts are upheld and provide independent oversight of the general operations of care facilities, hospitals and mental health treatment services.[292] The Ministry of Health guidelines for District Inspectors describes the three main roles of an Inspector:[293]

> - ensuring that every individual who is subject to a compulsory assessment and treatment order under the Act is cared for in accordance with the statutory requirements of the Act and the principles of natural justice
>
> - monitoring of mental health services providing treatment to persons with mental disorders, as defined by the Act, to ensure their continued smooth and efficient operation and assist with quality improvement at the service level through visits to the different services
>
> - investigating complaints and conducting enquiries.

[493] A care recipient can also make a complaint of breach of rights to the responsible District Inspector, i.e. the District Inspector that has been allocated to monitor or oversee the care recipient. Under s 98 of the IDCCR Act, the responsible District Inspector must investigate the complaint and attempt to talk with the care recipient or anyone else involved in the case. After an initial investigation of the complaint, the District Inspector, if satisfied that the complaint has substance, must conduct an inquiry under s 101 into the complaint or report the matter with any recommendations to the Care Manager.[294] Such a report is also sent to the Director-General of Health.[295]

[494] If the complaint involves a breach of a right under the Code of Rights, the District Inspector must notify the Health and Disability Commissioner. If the care

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291 Mental Health (Compulsory Assessment and Treatment) Act 1992, s 94; and Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 144.

292 Mental Health (Compulsory Assessment and Treatment) Act 1992, ss 94–98; and Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, Part 7, Subpart 1.

293 Ministry of Health *Guidelines for the Role and Function of District Inspectors: Appointed under the Mental Health (Compulsory Assessment and Treatment) Act 1992* (February 2012) at [2.2].

294 Intellectual Disability (Compulsory Care and Rehabilitation) Act s 98(3).

295 Section 98(4).

recipient is not satisfied with the outcome of the complaint, he or she may request the Director-General of Health to examine the complaint.[296] On the receipt of the District Inspector's report under s 98, the Care Manager must take all steps necessary to correct every deficiency identified in the report.[297] In New Zealand, the District Inspector position provides a comprehensive oversight role over IDCCR care recipients.

[495] The Centre for Mental Health research has commented that the role of the District Inspector fits well under the United Nations Convention on the Rights of Persons with Disabilities.[298] As the Convention calls for a codification of broad rights to advocacy in relation to decision-making of patients under mental health legislation, the Centre identifies that the District Inspector role meets this purpose.

[496] The Centre for Mental Health Research has also identified that the District Inspector role provided in New Zealand is unique.[299] It drew a comparison with other jurisdictions as follows:

> Readings of international law suggest the [New Zealand] DI role is unique. Although various jurisdictions permit access to advice regarding individual's legal rights while being detained under mental health legislation, this is not a guaranteed statutory service provided solely by dedicated lawyers.

[497] The way in which a District Inspector operates in New Zealand is exemplified in J's case, where a District Inspector, designated under s 144 of the IDCCR Act, is appointed as the liaison District Inspector for J specifically.

J's liaison District Inspector

[498] Rosaline Fuata'i is a District Inspector designated by the Director-General of Health for the purposes of the IDCCR Act for the Auckland Region. Of the four designated District Inspectors for the region, Ms Fuata'i is the liaison District Inspector for J.

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296 Section 99(2).
297 Section 100.
298 Katey Thom and others *Safeguarding the rights of people detained for compulsory psychiatric treatment: The role of the District Inspector* (Centre for Mental Health Research, July 2013) at 13.
299 At 13.

[499] Prior to a review being undertaken every six months of a care recipient's condition and status, the Care Coordinator must present a report to the Family Court on the continued appropriateness of the contents of the care and rehabilitation plan. Ms Fuata'i confirmed with the Court that she was served with a copy of the Care Coordinator's report on the appropriateness of J's order and plan dated 29 September 2016. Ms Fuata'i had also been served with a copy of the Care Coordinator's application for an extension under s 85 and the accompanying application under s 87, to defer the expiry of the compulsory care order until the extension application could be heard. J, through his welfare guardian, had also filed an application to cancel the compulsory care order and oppose the application for deferral; the District Inspector had been served with those applications also.

[500] As canvassed under Part 2,[300] the Family Court directed Ms Fuata'i to file a report, in which Ms Fuata'i addressed the issues arising over J's care and risk. She suggested that a lead care person be appointed to coordinate the various agencies input into J's care. As a result, NIDCA took more of a lead role in coordinating referrals and input from the different service providers and was convening monthly meetings among the providers, the Care Manager and J's mother to discuss matters of concern and how they could be addressed. The District Inspector had attended meetings, where other options for J's accommodation and care were also canvassed and took part in the Family Court hearing.

[501] In the inquiry hearing before me, I sought a response from the District Inspector about the matters raised with the Ministry of Health over J's status or care. Ms Fuata'i filed a memorandum dated 10 July 2017, accompanied by her two memoranda to the Family Court and the issues that she had raised specifically with the Ministry. These included:

(a) J's continuing status as a care recipient and the issue of proportionality, i.e. the length of the period of care as a care recipient in the index offending;

(b) the review of J's care and rehabilitation plan six monthly;

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300 At [264] of this judgment.

(c) her monitoring of J's reviews;

(d) making recommendations as to the appropriateness of care and rehabilitation as directed by the Courts;

(e) raising the concerns from J's mother, particularly the lack of communication and/or consultation between her and J's staff; and

(f) the need for proper documentation of observations and serious incidents and timely investigations of incidents by the Care Manager or appropriate person.

[502] As I have canvassed under Part 3, Ms Fuata'i confirmed that J's mother can make contact with her regarding any concerns or issues over J's care, including the options of funding packages and home modifications for J. Ms Fuata'i confirmed that a significant part of her role in J's case included monitoring processes between agencies involved in delivering care and monitoring the care and rehabilitation plan, to ensure that the services are delivered appropriately to J for the purpose of rehabilitation, congruent with J's rights under the legislation.

[503] The role of the District Inspector is amply demonstrated in this case, where Ms Fuata'i has reported to both the Family Court Judge and to this Court on the issues surrounding J's current care. It highlights that New Zealand has a robust system of oversight and monitoring of care recipients under the IDCCR Act, by qualified and experienced lawyers, who are served with the reports prior to a review hearing and can provide a report to the presiding Judge, when directed. They are independent and undertake an oversight and monitoring role, which is an important safeguard against arbitrary detention and inappropriate treatment of care recipients.

Conclusion

[504] J's detention, although prolonged, is not arbitrary:

(a) J's detention is lawful under the CPMIP Act and the IDCCR Act. J's detention is based on his risk to himself and others, as well as his need for treatment and rehabilitation because of his intellectual disability.

(b) J's risk has been measured and assessed by a number of specialist health practitioners, who all affirm the need for J to remain in secure compulsory care, because of the risk to himself and others.

(c) The conditions in which J was held, prior to the variation on his case order in February 2017 did not render J's detention unlawful.

(d) J's detention is not disproportionate and is justified for purposes which align with the principles discussed in the international and New Zealand cases.[301] This review ground is dismissed.

[505] In addition, the three safeguards built into the New Zealand IDCCR legislation, mitigate against the risk of arbitrary detention. They are:

(a) the legislative requirements for six monthly reviews of compulsory care orders;

(b) care orders are time limited and individually focussed; and

(c) there is District Inspector monitoring and oversight of care recipients.

Discrimination

[506] Dr Ellis, on behalf of J, argues that J has been discriminated against because of his intellectual disability. This submission was made in relation to three of the proceedings as follows:

(a) *CPMIP Act criminal appeal*: the 2005/2006 District Court decisions to detain J and order his care as a care recipient because of his risk, based on his intellectual disability, were discriminatory and an arbitrary

[301] *Neilsen*, above n 251; *Zaoui*, above n 252; *Miller*, above n 253; *Rameka*, above n 261; and *Fardon*, above n 262.

detention. J was not considered for diversion, nor was he allowed to stand trial. J received "a sentence" disproportionate to his offending.

(b) *Family Court appeal*: the 2017 decision of Judge Goodwin to extend and vary J's care order to provide for secure care was discriminatory.[302]

(c) *Judicial review claim*: J's detention because of his intellectual disability was discriminatory and the statutory processes under the CPMIP Act and IDCCR Act breach numerous rights in the NZBORA.

[507] Overall, Dr Ellis submits the statutory schemes under ss 9 and 14 of the CPMIP Act and the IDCCR Act are discriminatory. Dr Ellis submits they are inconsistent with the Statute of Westminster 1275,[303] the Convention on the Rights of Persons with Disabilities,[304] the International Covenant on Civil and Political Rights,[305] and the NZBORA. In terms of relief, Dr Ellis seeks a declaration of inconsistency about the discriminatory nature of these statutory schemes.[306]

[508] The Crown submits the Court cannot refuse to apply the provisions of the CPMIP Act even if they are inconsistent with NZBORA or with other authorities. The CPMIP Act and existing case law stand. The only possible remedy to the lawful application of a discriminatory statute would be a declaration that the CPMIP Act is inconsistent with NZBORA.

[509] However, the Crown submits that a declaratory remedy is not available in a CPMIP Act appeal, as the Act mandated only limited remedial powers.[307] Further, the Crown submits the international conventions, on which Dr Ellis relies, do not directly

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302 Dr Ellis did not make a specific submission on discrimination in the Family Court appeal but submits under the CPMIP Act appeal that the discrimination arguments relate to the Family Court appeal also.

303 Statute of Westminster 1275 (UK) 3 Edw I c 1.

304 Convention on the Rights of Persons with Disabilities 2515 UNTS 3 (opened for signature 30 March 2007, entered into force 3 May 2008).

305 International Covenant, above n 260.

306 Dr Ellis relies on *Taylor v Attorney-General* [2017] NZCA 215, [2017] 3 NZLR 24 at [187] where the Court of Appeal held the higher courts of New Zealand have jurisdiction to make a declaration of inconsistency, which derives from the power of the higher courts to answer questions of law and is confirmed by the NZBORA.

307 Criminal Procedure (Mentally Impaired Persons) Act 2003, s 17.

apply in New Zealand,[308] and the Courts will not give declarations of inconsistency with those conventions.[309] In any event, the Crown argues the CPMIP Act process is not discriminatory.

The "discriminatory process" under the CPMIP Act and IDCCR Act

[510] At the 7 February 2005 hearing under ss 9 and 14 of the CPMIP Act, the District Court found on the balance of probabilities, that J was involved in the alleged offending (s 9) and was unfit to stand trial (s 14). J was bailed to reside at the Solway Trust a care facility.

[511] After obtaining various health assessment reports, a disposition hearing was held on 8 February 2006. The Court ordered J be cared for as a care recipient under s 25(1)(b) of the CPMIP Act.[310] Under s 26(2) of the CPMIP Act, that order was deemed to be an order for the purposes of the IDCCR Act.

[512] Since that time, J's compulsory care order has been repeatedly reviewed and extended under the IDCCR Act, the latest decision being made by Judge Goodwin on 27 February 2017,[311] which extended J's compulsory care order and varied it to place J in secure care.

[513] Dr Ellis argues that the consequence of the combined statutory schemes in the CPMIP Act and the IDCCR Act is a new form of preventive detention, which creates potentially indefinite detention. Dr Ellis submits this is discriminatory.

[514] In dealing with this submission, I first review the authorities on discrimination from New Zealand and canvass the parties' submissions in relation to them. I then consider the authority from the overseas jurisdictions.

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308 *Taunoa v Attorney-General* (2004) 7 HRNZ 379 (HC) at [281].
309 *Miller*, above n 253, at [12]–[13], [19(e)], [49] and [51].
310 *Disposition decision*, above n 30.
311 *Goodwin decision*, above n 95.

New Zealand authorities

[515] Section 19(1) of the NZBORA provides that everyone has the right to freedom from discrimination on prohibited grounds. Section 21(1) of the Human Rights Act 1993 outlines these prohibited grounds and includes:

> (h) disability, which means—
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> (i) physical disability or impairment:
>
> (ii) physical illness:
>
> (iii) psychiatric illness:
>
> (iv) intellectual or psychological disability or impairment:
>
> (v) any other loss or abnormality of psychological, physiological, or anatomical structure or function:
>
> (vi) reliance on a guide dog, wheelchair, or other remedial means:
>
> (vii) the presence in the body of organisms capable of causing illness:

[516] In order to determine whether there is discrimination under s 19 of the NZBORA, the Court must consider whether:[312]

> (a) there is different treatment or effects between the complainant and a group in comparable circumstances on the basis of a prohibited ground of discrimination; and
>
> (b) that treatment or effect results in material disadvantage.

[517] If discrimination is found, the impairment must be minimal and proportionate to the importance of the objective for the right to be curtailed.[313] Under s 5 of the NZBORA, the onus is on the Crown to demonstrably justify the limit as reasonable.

[518] Section 19(2) of the NZBORA deems that affirmative action is not discrimination:

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312 *Ministry of Health v Atkinson* [2012] NZCA 184, [2012] 3 NZLR 456 at [55], [109] and [136]; and *Child Poverty Action Group Inc v Attorney-General* [2013] NZCA 402, [2013] 3 NZLR 729 at [43]. More recently, this approach was confirmed by the Court of Appeal in *Ngaronoa v Attorney-General* [2017] NZCA 351, [2017] 3 NZLR 643 at [116]–[118].

313 *R v Hansen* [2007] NZSC 7, [2007] 3 NZLR 1 at [104]; *Atkinson*, above n 312, at [143]; and *Child Poverty*, above n 312, at [76].

> (2) Measures taken in good faith for the purpose of assisting or advancing persons or groups of persons disadvantaged because of discrimination that is unlawful by virtue of Part 2 of the Human Rights Act 1993 do not constitute discrimination.

[519] The authors of *The New Zealand Bill of Rights Act: A Commentary* view s 19(2) as an aid to recognising the kind of formal discrimination that will be justifiable in terms of s 5 and thus lawful, rather than an exception to the right guaranteed in s 19(1).[314]

[520] The compatibility of the CPMIP Act with human rights protections was considered by the Court of Appeal in *Ruka v R*.[315] In that case, Dr Ellis raised similar arguments, namely, that the legislative scheme of the CPMIP Act created a discriminatory criminal justice process, as it only applied to persons suffering a mental impairment. The Court rejected these arguments, primarily on the grounds of parliamentary sovereignty:[316]

> A powerful starting point is our acknowledgment of Parliament's sovereignty. Judges in this country have no power to question or decline to apply legislative enactments. The judicial function is limited to interpretation of the laws passed by Parliament. In the absence of an express legislative mandate, we cannot determine that a process laid down by Parliament should not be followed even if we were persuaded that it was discriminatory.
>
> … the legislature enacted the CPMIP Act, with related references to the Intellectual Disability (Compulsory Care and Rehabilitation) Act, to restate and reform the law relating to fitness to plead. Parliament has, following a deliberative process, created prescriptive processes for determining trial fitness for those whose mental capacities may be called into doubt after a criminal prosecution is initiated.

[521] The Court also considered s 21B(1) of the Human Rights Act, which provides that any act of any person or body is not unlawful if that act is authorised or required by an enactment of otherwise by law.[317] As the acts of a court or a judge under ss 9 to 14 of the CPMIP Act were mandated by that Act, s 21B(1) of the Human Rights Act stipulates that they are not unlawful.

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314 Andrew Butler and Petra Butler *The New Zealand Bill of Rights Act: A Commentary* (2nd ed, LexisNexis, Wellington, 2015) at [17.19.5].

315 *Ruka*, above n 93.

316 At [86]–[87] (footnote omitted).

317 At [90]–[91].

[522] The Court considered the decisions of appellate courts in other jurisdictions, which have also dismissed challenges to the constitutional integrity of legislation similar to the CPMIP Act.[318]

[523] The Court observed that the procedures in ss 9 to 14 of the CPMIP Act reinforce the balance between protecting two interests: the public interest in detaining and treating those who present a high risk through no fault of their own compared to the interests of the defendant, who needs care and assistance and should not face the punitive response of conviction and sentence. The Court held s 9 creates a lower threshold for state intervention and provides an appropriate mechanism for balancing these interests by excluding the requirement to prove the mental element of the offence. As a result, the formal sanctions of punishment are removed for those found unfit to stand trial.

[524] Dr Ellis challenges the validity of the *Ruka* decision. He submits *Ruka* is distinguishable because the Statute of Westminster 1275 and international jurisprudence were not considered in that case. The Crown rejects this and submits these authorities do not add substantively to the test for discrimination under s 19 of the NZBORA.

[525] More recently, in *S v Attorney-General*, Ellis J observed that *Ruka* remains relevant and authoritative for the proposition that the CPMIP Act cannot be impugned as discriminatory and contrary to law as it is a statutory process enacted by Parliament.[319] In that case, Ellis J determined that those found unfit to stand trial are not discriminated against on the basis of their qualifying disability (intellectual disability or psychiatric illness) because they are not convicted of any offence and there is no minimum period of detention before release can occur. In addition, there are a number of reviews, inquiries and appeals in place to ensure the detention is not arbitrary.[320]

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318 *R v Antoine* [2001] 1 AC 340 (HL); and *R v H* [2003] UKHL 1, [2003] 1 WLR 411.
319 *S*, above n 10, at [677], citing *Ruka*, above n 93, at [89]–[91] and [94].
320 *S*, above n 10, at [683] and [685].

Discussion

[526] In order to determine whether J has been unjustifiably discriminated against under s 19 of the NZBORA, I will apply and consider three issues, as directed by the Court of Appeal in *Atkinson v Ministry of Health* and *Child Poverty Action Group Inc v Attorney-General*:[321]

(a) using a comparator group, whether there is a difference in the treatment or effects between J and a group in comparable circumstances, on the basis of a prohibited ground of discrimination;[322]

(b) whether that treatment or effect results in material disadvantage for J; and

(c) if the answer to the first two questions is yes, and there is discrimination, whether that discrimination is demonstrably justified under s 5 of the NZBORA.

a) Comparator group

[527] The Crown submits that ordinary offenders and those who are unfit to stand trial are not in comparable circumstances. Given the lack of analogy between ordinary offenders and those unfit to stand trial, any difference in treatment does not amount to discrimination. Further, by treating these two groups differently, the legislation promotes, rather than undermines, equality. For these reasons, the Crown submits a comparator exercise, as usually undertaken for discrimination claims, is unhelpful.

[528] If a comparator group is to be selected, the Crown submits the closest comparator group is a non-disabled offender who poses the same degree of risk to others as J, but not because of a disability. The Crown highlights that the element of comparable risk is important.[323] Non-disabled offenders who pose a high degree of

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321 *Atkinson*, above n 312, at [55], [109] and [143]; *Child Poverty Action Group*, above n 312, at [43] and [76]; and as discussed at [517]–[518] of this judgment.

322 As listed in s 21(1) of the Human Rights Act 1993.

323 Relying on *Winko v Forensic Psychiatric Institute* [1999] 2 SCR 625 at [182]–[186]; and *RIDCA* above n 64, at [75].

risk to others are likely to be sentenced to preventive detention in New Zealand.[324] In light of J's level of risk, particularly his frequent attempts to kill people and cut off their feet, his repeated assaults and attempts to obtain weapons, the Crown submits J's risk is comparable to those who would be sentenced to preventive detention.

[529] Although both groups are detained while their risk of harm continues, it is wrong to consider preventive detention on the same footing as compulsory care orders under the IDCCR Act, because the purposes of those regimes are different. While a person's liberty is similarly restricted, the treatment and care offered to the two groups is different in quality, as I have already discussed.[325]

[530] Despite the difficulties in making this comparison, if a comparator group needs to be identified, the closest group is non-disabled offenders who pose the same degree of risk as J. Both groups have a high level of risk, which allows the Court to assess whether there is a difference in treatment based on J's intellectual disability. Using this comparator, there is a difference in treatment between the two. J, because of his intellectual disability and level of risk, is subject to a compulsory care order in secure care. Whereas, non-disabled offenders who pose the same degree of risk, will likely be serving a sentence of preventive detention in prison.

b) Material disadvantage

[531] The Crown submits that disabled people deemed unfit to stand trial who are subject to a compulsory care order are not materially disadvantaged by the difference in treatment. These processes provide a non-criminal alternative to a criminal process the defendant has no capacity to participate it. The Crown categorises this as a reasonable accommodation of disability, rather than unlawful discrimination. The Crown argues the CPMIP Act regime is designed to avoid the prejudice of a criminal proceeding for intellectually disabled persons and to protect the public from the risk such persons may pose. Further, compulsory care orders are care and rehabilitation orders responding to disability-related needs and risk to others (including risk of further offending).

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324 Sentencing Act 2002, s 87.
325 At [477] of this judgment.

[532] I accept the Crown's submission. In this case, J's treatment has not materially disadvantaged him as it has been appropriate, given his health needs and the risk he poses to others. A care order means that J is not found guilty of an offence, he is not detained in a prison for punishment purposes, he has a right to receive rehabilitation appropriate to his condition and there is no minimum period of detention before release can occur. The Crown submits there is no discrimination here.

[533] I consider that although there is differential treatment, there is no material disadvantage caused to persons who are subject to the CPMIP Act process. Rather, that process is designed to achieve procedural fairness by accommodating the mental impairment or intellectual disability of the accused. As Gendall J commented in *R v Mulholland*:[326]

> At the heart of the rules of law surrounding fitness to stand trial, lies the paramount premise that every person accused of a crime has a right to a fair trial.[327] In relation to the issue of mental impairment, the fundamental concern is the ability to participate in the trial, which includes the presentation of a defence.[328]

[534] The compulsory care order scheme is designed to respond to and treat disability-related needs and the risk of the person to themselves and others. The review safeguards and complaints procedures available under the IDCCR Act, once a person is subject to a compulsory care order, exist to respond to any change in a care recipient's needs or risk and to ensure there is oversight over all decisions.[329]

[535] A consistent theme in the Corrections and Ombudsman's reports illustrate the problems arising from the high number of prisoners with mental health or disability needs and the lack of available or suitable services.[330] The care order scheme under

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326 *R v Mulholland* [2015] NZHC 881 at [91].

327 New Zealand Bill of Rights Act 1990, s 25(a).

328 Section 25(e).

329 As discussed at [479]–[503] of this judgment.

330 While one in five New Zealanders experience mental illness in their lifetime, a recent Corrections report identified that 91 per cent of prisoners had a lifetime diagnosis of a mental health or substance use disorder: Department of Corrections *Change Lives Shape Futures: Investing in better mental health for offenders* (2016) at 4. A further study commissioned by Corrections in June 2016 presents similar figures and notes that the high rates of mental health and substance use disorders within the prison population are often undetected and under-treated: Devon Indig, Craig Gear and Kay Wilhelm *Comorbid substance use disorders and mental health disorders among New Zealand prisoners* (Department of Corrections, June 2016) at vii. In 2012, the Ombudsman's report on health services available to prisoners concluded prison healthcare was reactive rather than proactive and mental healthcare in New Zealand prisons is inadequate or unsuitable: Beverley

the IDCCR Act, far from materially disadvantaging the intellectually disabled, provides a humane, fair and compassionate system for their care and rehabilitation. I do not consider the "differential treatment" is discriminatory, when the alternative would mean a person's ability to participate in a trial is compromised and any consequent prison sentence does not consist of or provide suitable services for those persons with intellectual disabilities.

c) Justified discrimination?

[536] Although I have found the differential treatment for the mentally impaired is not discriminatory, if I am wrong and discrimination is established, this would be justified discrimination under s 5 of the NZBORA, as the Crown submits, because:

(a) an order for care as a special care recipient ensures appropriate rehabilitation and care is received;

(b) a finding of unfitness avoids the possibility of an unfair criminal prosecution and convictions; and

(c) such treatment protects the public from dangerous behaviour in circumstances where a care recipient may have little insight into the impact of their actions on others.

Wakem and David McGee *Investigation of the Department of Corrections in relation to the Provision, Access and Availability of Prisoner Health Services* (2012) at 121-122. In the 2015-2016 annual report, the Chief Ombudsman commented that the circumstances of those who are detained and suffer from mental health issues is concerning. The reported noted "We have become increasingly concerned at the inadequacy of appropriate facilities, especially for prisoners who have high mental health needs": Peter Boshier *Annual report 2015/2016* (Office of the Chief Ombudsman, June 2016) at 11. Recently, IHC New Zealand highlighted that people with intellectual disabilities, including those suffering foetal alcohol spectrum disorder, are invisible in Corrections policies targeting mental health in prisons. IHC's Director of Advocacy, commented: "Despite there being an alternative process for people with intellectual disabilities under the Intellectual Disability (Compulsory Care and Rehabilitation) Act, far too many are ending up in the prison system without adequate ongoing support… Far too often intellectual disability and poor mental health combine, leaving people totally isolated and vulnerable in our prisons": IHC New Zealand "People with intellectual disabilities missing from mental health announcement" (press release, 19 July 2017).

[537] If the CPMIP Act or IDCCR Act is inconsistent with the NZBORA, this Court cannot decline to apply those Acts or deem any provision of those Acts ineffective.[331] This is particularly so, if the limits prescribed under those two Acts are reasonably and demonstrably justified, under s 5 of the NZBORA, which I find, in the alternative, that they are.

Statute of Westminster

[538] Dr Ellis relies on the Statute of Westminster 1275 (UK), which, so far as it remains in force in New Zealand, provides:[332]

> The King willeth and commandeth ... that common right be done to all, as well poor as rich, without respect of persons.

[539] Dr Ellis argues that the Statute is relevant to discrimination generally (in this case discrimination on the basis of intellectual disability) not just financial discrimination as the literal words of the Statute suggest. The CPMIP Act process is submitted as contrary to the Statute of Westminster as it discriminates against J and goes against the concepts of fairness and justice.[333]

[540] Although the Statute of Westminster has been incorporated into New Zealand law, s 19(1) of the NZBORA expressly provides for the right to be free from discrimination on the grounds of an intellectual disability. NZBORA is a later, more specific statute and it is more directly applicable to J's case. The test for discrimination enunciated in *Atkinson* and *Child Poverty Action Group* remains in force and J would still need to satisfy this in order to establish the CPMIP Act and/or IDDCR Act schemes are discriminatory.[334] I have already determined that J's claim does not satisfy this test.

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331 New Zealand Bill of Rights Act 1990, s 4.
332 Imperial Laws Application Act 1988, sch 1.
333 Relying on *R v Taito* [2001] UKPC 50, [2003] 3 NZLR 577 at [19]–[20]; and *Thomas v Baptiste* [2000] 2 AC 1 (PC).
334 *Atkinson*, above n 312; and *Child Poverty Action Group*, above n 312.

Authorities from overseas jurisdictions

[541] I now consider some of the relevant cases from other jurisdictions, to provide examples of how similar issues facing this Court, have been dealt with elsewhere.

United Kingdom

[542] In *R v H*,[335] the House of Lords held that the procedure for determining fitness to stand trial was fair and compatible with the rights of the accused person to a fair trial under art 6 of the European Convention on Human Rights.[336] The regime in the United Kingdom is similar to the process under the CPMIP Act, with the noticeable difference that the question of fitness to be tried was, at the time *R v H* was heard, to be determined by a jury.[337]

[543] The Court held that the process conducted to determine if an accused is unfit to stand trial is not unfair. Lord Bingham, for the Court, held:[338]

> It is very much in the interest of such persons that the basic facts relied on against them (shorn of issues concerning intent) should be formally and publicly investigated in open court with counsel appointed to represent the interests of the person accused so far as possible in the circumstances. The position of accused persons would certainly not be improved if section 4A were abrogated.[339]

[544] His Lordship further commented:[340]

> The procedure under section 4A must always, of course, be conducted with scrupulous regard for the interests of the accused person, but the procedure if properly conducted is fair and it was not suggested that the procedure was not properly conducted in this case.

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335 *R v H*, above n 318.

336 European Convention for the Protection of Human Rights and Fundamental Freedoms ETS 5 (signed 4 November 1950, entered into force 3 September 1953).

337 Criminal Procedure (Insanity) Act 1964 (UK), s 4(5). This was amended by the Domestic Violence, Crime and Victims Act 2004 (UK), s 22(2) and now the question of fitness to be tried shall be determined by the court with a jury.

338 *R v H*, above n 318, at [18].

339 Section 4A is the equivalent of s 9 of the CPMIP Act and involves a finding that the accused did the act or made the omission charged against him.

340 At [20].

Canada

[545] In *Winko v Forensic Psychiatric Institute*,[341] the Canadian Supreme Court declined to find that a statutory regime similar to the CPMIP Act (Part XX.1 of the Criminal Code)[342] breached the "equality" provision (s 15(1)) in the Canadian Charter of Rights and Freedoms.[343] McLachlin J, for the majority, identified that these procedures treat offenders who are unfit to stand trial (or not criminally responsible) in a different way to other offenders:[344]

> The NCR [not criminally responsible] accused is to be treated in a special way in a system tailored to meet the twin goals of protecting the public and treating the mentally ill offender fairly and appropriately. Under the new approach, the mentally ill offender occupies a special place in the criminal justice system; he or she is spared the full weight of criminal responsibility, but is subject to those restrictions necessary to protect the public.

[546] However, the Court confirmed that this regime advantages rather than disadvantages those who are subject to it. McLachlin J held:[345]

> An analysis of these provisions of the Criminal Code and their effect upon NCR accused reveals them to be the very antithesis of discrimination and hence not to engage the protections of s. 15(1). Part XX.1 does not reflect the application of presumed group or personal characteristics. Nor does it perpetuate or promote the view that individuals falling under its provisions are less capable or less worthy of respect and recognition. Rather than denying the dignity and worth of the mentally ill offender, Part XX.1 recognizes and enhances them.
>
> …
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> Consider the example of the hearing impaired, recently reviewed by this Court in *Eldridge*, *supra*. If a law stated that hearing impaired people did not have the right to public medical treatment, it would treat the hearing impaired individual differently from others. It would likely be characterized as discriminatory, in the sense that concept is understood in our s. 15(1) jurisprudence. But as is clear from *Eldridge*, a law that treats the hearing impaired <u>like</u> others may also deny equal medical treatment, by failing to recognize the special situation of hearing impaired people which requires that they be provided with translation services in order to communicate with medical personnel. In the first case, the law discriminates by treating the individual <u>differently</u> on the basis of a group characteristic; in the second, the law discriminates by <u>failing to take account</u> of a group characteristic when the

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341 *Winko*, above n 323.
342 Criminal Code RSC 1985 c C-46.
343 Canadian Charter of Rights and Freedoms, Part I of the Constitution Act 1982 (C), being Schedule B to the Canada Act 1982 (UK), 1982, c 11.
344 At [30].
345 At [81] and [83] (emphasis original).

> special position of the individual mandates that it should do so. … Regardless of how the discrimination is brought about, the effect is the same – to deny equal treatment on the basis of an unfounded assumption. It follows that different legal treatment reflecting the particular needs and circumstances of an individual or group may not only be justified, but may be required in order to fulfill s. 15(1)'s purpose of achieving substantive equality.

[547] The Court held it was not the intention of Parliament to discriminate against those unfit to stand trial as the legislative history of the provisions indicate it was adopted for the purpose of eliminating the stereotyping and stigmatisation that mentally ill accused had suffered historically. Rather, it was Parliament's intention "to combat discrimination and treat individuals who commit criminal acts which they cannot know are wrong in a way appropriate to their true situation."[346]

[548] Further, the Court held the provisions were not discriminatory as they treated each defendant on the basis of his or her actual situation, not on the basis of the group to which he or she is assigned (i.e. persons who are intellectually disabled). Before a person comes under the legislation there must be an individual assessment conducted by a trial judge based on evidence, with full access to counsel and other constitutional safeguards. The Court identified that this individualised treatment does not disadvantage the accused but treats them more appropriately and equally.

[549] I find this reasoning persuasive in J's case and equally applicable to the New Zealand context. The CPMIP Act process is designed to identify the individual circumstances of a defendant and recognises that the ordinary criminal justice process (trial, conviction and potentially imprisonment) is not appropriate for someone who is intellectually disabled. This assessment is done for each individual however and is designed to treat a person appropriately based on their circumstances so that they are not treated like any other defendant and thus unequally.

[550] I now turn to consider the international conventions and their impact on discrimination in this case.

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346 At [85].

International conventions

[551] Dr Ellis relies on two key international conventions: the International Covenant on Civil and Political Rights (ICCPR) and the Convention on the Rights of Persons with Disabilities (CRPD).[347]

[552] International law is only part of domestic law to the extent that Parliament has incorporated it into the domestic system.[348] As far as possible, statutes should be read in a way which is consistent with New Zealand's international law obligations.[349] However, the extent to which international conventions can be used is constrained by the principle that interpreting a statute consistently with international law obligations can only be done if the words of the statute allow it.[350]

ICCPR – Civil Political Rights Covenant

[553] Dr Ellis relies on arts 14(1) and 26 of the ICCPR. Article 14(1) provides for the right of equality before courts and tribunals as well as the right to a fair trial. Article 26 of the ICCPR provides for the right of freedom from discrimination.

[554] The ICCPR was signed by New Zealand in 1968 and ratified in 1978.[351] Recital (b) of the long title to the NZBORA states it is an act "to affirm New Zealand's commitment to the International Covenant on Civil and Political Rights." The authors of *The New Zealand Bill of Rights Act: A Commentary* note that this indicates the NZBORA anticipated that references to the ICCPR and Human Rights Committee commentary would have a significant role to play in interpreting the NZBORA.[352]

[555] Part IV of the ICCPR established the Human Rights Committee, which monitors the progress of states on the measures adopted to give effect to the ICCPR and considers complaints against states about their violation of ICCPR rights. The Human Rights Committee also issues "general comments" which indicate the scope

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347 International Covenant, above n 260; and Convention on Rights of Persons with Disabilities, above n 304.
348 *Butler*, above n 314, at [4.5.12].
349 See, for example, *Huang v Minister of Immigration* [2008] NZCA 377, [2009] 2 NZLR 700 at [34].
350 See, for example, *R v D*, above n 52, at [25].
351 *Butler*, above n 314, at [3.6.10].
352 At [4.5.1].

of rights guaranteed by the ICCPR and guide states in their practice of protecting ICCPR rights.

[556] In its *General comment No. 32*, the Human Rights Committee addressed art 14 of the ICCPR and affirmed the importance of the right to equality before courts.[353] The Committee commented that access to the administration of justice must be guaranteed in all cases, without distinction based on any grounds, to ensure that no individual is deprived of their right to claim justice.[354]

[557] The Human Rights Committee has not yet produced a general comment on art 26 of the ICCPR. However, in its *General comment No. 35*, the Committee recommended that states revise outdated laws and practices in the field of mental health and in relation to persons with disabilities to avoid arbitrary detention.[355] The Committee highlighted that any deprivation of liberty based on the grounds of disability must only be used in certain circumstances and not as a general method of treatment. The Committee commented:[356]

> The existence of a disability shall not in itself justify a deprivation of liberty but rather any deprivation of liberty must be necessary and proportionate, for the purpose of protecting the individual in question from serious harm or preventing injury to others. It must be applied only as a measure of last resort and for the shortest appropriate period of time, and must be accompanied by adequate procedural and substantive safeguards established by law. The procedures should ensure respect for the views of the individual and ensure that any representative genuinely represents and defends the wishes and interests of the individual. States parties must offer to institutionalized persons programmes of treatment and rehabilitation that serve the purposes that are asserted to justify the detention. Deprivation of liberty must be re-evaluated at appropriate intervals with regard to its continuing necessity. The individuals must be assisted in obtaining access to effective remedies for the vindication of their rights, including initial and periodic judicial review of the lawfulness of the detention, and to prevent conditions of detention incompatible with the Covenant.

[558] There is nothing in this recommendation that indicates New Zealand's practice under the CPMIP Act and IDCCR Act would qualify as discriminatory. The

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353 Human Rights Committee *General comment No. 32: Article 14 (Right to equality before courts and tribunals and to a fair trial)* XC CCPR/C/GC/32 (2007).

354 At [9].

355 Human Rights Committee *General comment No. 35: Article 9 (Liberty and security of person)* CXII CCPR/C/GC/35 (2014) at [19].

356 At [19] (footnotes omitted).

Committee notes deprivation of liberty should be a measure of last resort, for short periods of time, with regular reviews: all of which the CPMIP Act and IDCCR Act provide for. The Committee identifies that while disability itself cannot be grounds for depriving an individual of their liberty, detention may be appropriate in particular circumstances. The Committee is therefore not as emphatic that any differential treatment is discriminatory. However, the views of the Committee on the Rights of Persons with Disabilities differ, as discussed below.

CRPD – the disability convention

[559] The relevant articles of the CRPD relied on are:

(a) art 5, which provides for the right of equality and non-discrimination before the law;

(b) art 12, which provides persons with disabilities the right to equal recognition and legal capacity before the law and outlines that states parties must take appropriate measures to facilitate this access;

(c) art 13, which provides that states parties ensure effective and equal access to justice for persons with disabilities; and

(d) art 14, which provides for the right to liberty and security of the person and the right not to be unlawfully or arbitrarily detained.

[560] New Zealand ratified the CRPD on 24 September 2008, after Parliament enacted the Disability (United Nations Convention on the Rights of Persons with Disabilities) Act 2008 and the Human Rights Amendment Act 2008.[357]

[561] Compliance with the CRPD is monitored by the Committee on the Rights of Persons with Disabilities, which was established under art 34 of the CRPD. Similar to the Human Rights Committee, the Committee on the Rights of Persons with Disabilities may receive complaints about alleged state breaches of the Convention.

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357 *Butler*, above n 314, at [3.6.44].

[562] Dr Ellis argues there has been a paradigm shift in the Committee on the Rights of Persons with Disabilities, from a social welfare response to disability towards a rights-based approach. The Committee opined there should be an absolute prohibition of depriving individuals of their liberty on the basis of disability, as this is a discriminatory practice.[358] The Committee's comments mean "disability can never be considered a criterion to justify a deprivation of liberty, not even in combination with other grounds such as care, medical necessity, and alleged dangerousness to oneself or others."[359] In its *Guidelines on art 14*, the Committee identified there is an absolute prohibition on detention based on impairment as it is arbitrary detention and commented:[360]

> 14. Persons with intellectual or psychosocial impairments are frequently considered dangerous to themselves and others when they do not consent to and/or resist medical or therapeutic treatment. All persons, including those with disabilities, have a duty to do no harm. Legal systems based on the rule of law have criminal and other laws in place to deal with the breach of this obligation. Persons with disabilities are frequently denied equal protection under these laws by being diverted to a separate track of law, including through mental health laws. These laws and procedures commonly have a lower standard when it comes to human rights protection, particularly the right to due process and fair trial, and are incompatible with article 13 in conjunction with article 14 of the Convention.

[563] The Committee further commented that declarations of unfitness to stand trial in criminal justice systems, and the detention of persons based on those declarations, are also contrary to art 14 of the CRPD.[361]

[564] In relation to New Zealand specifically, the Committee has expressed concerns about the conditions in which a person with disabilities can be declared unfit to stand

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358 See, for example, Centre for Civil and Political Rights *The UN Human Rights Committee a Year in Review* (2016) at 55; Committee on the Rights of Persons with Disabilities *Concluding observations on the initial report of New Zealand* CRPD/C/NZL/CO/1 (2014) at [33]–[34]; and Committee on the Rights of Persons with Disabilities *Concluding observations on the initial report of Portugal* CRPD/C/PRT/CO/1 (2016) at [32]–[33].

359 *Year in Review*, above n 358, at 55.

360 Committee on the Rights of Persons with Disabilities *Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities* XIV (2015).

361 *Guidelines on article 14*, above n 360, at [16].

trial and on that basis be deprived of their liberty.[362] However, the New Zealand Government has subsequently expressly rejected this recommendation.[363]

[565] Dr Ellis relies on the Committee on the Rights of Persons with Disabilities' views in *Noble v Australia* in 2016, as supporting this shift.[364] That opinion concerned the discriminatory nature of the process followed in Western Australia in relation to persons determined unfit to plead.

[566] In *Noble*, the Committee considered the Western Australian legislation and the process in Mr Noble's case was discriminatory because:

(a) it applies only to persons with cognitive impairment;

(b) it provides for such persons to be indefinitely detained without any finding of guilt when they are charged with criminal offences, while persons without cognitive impairments are protected from such treatment through the application of due process and fair trial;

(c) there was no opportunity for the defendant to exercise his legal capacity to plead not guilty and test the evidence against him;

(d) no adequate support was provided by the State to enable the defendant to stand trial and plead not guilty, despite his clear intention to do so; and

(e) after being determined unfit to plead, Mr Noble was detained in prison without having been convicted and after all charges against him were quashed, thus detaining him on the basis of his intellectual disability alone.

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362 *Concluding observations*, above n 358, at [33].

363 Office for Disability Issues *Government response to the United Nations Committee on the Rights of Persons with Disabilities' Concluding Observations on New Zealand* (Ministry of Social Development, June 2015) at [21].

364 Committee on the Rights of Persons with Disabilities *Views adopted by the Committee under article 5 of the Optional Protocol, concerning communication No. 7/2012 (Noble v Australia)* CRPD/C/16/D/7/2012 (2016)

[567] The Committee was concerned that Mr Noble's detention was primarily decided on the basis of the State's assessment of the potential consequences of his disability. In the absence of any criminal conviction, this converted his disability into the core cause of his detention, which violated art 14(1) of the CRPD, as Mr Noble's disability was the justification for depriving his liberty.

Discussion

[568] Although the United Nations Committee on the Rights of Persons with Disabilities cases provide further support for the right of persons to be free from discrimination, New Zealand has its own framework for determining whether discrimination on the grounds of intellectual disability exists. This framework, and the New Zealand decisions applying it, dictate the success or otherwise of J's claim and are the primary focus of this Court's decision.

[569] As Dr Ellis acknowledges, there is a difference in the rhetoric and recommendations espoused by the different United Nations Committees. This can make it difficult to interpret New Zealand legislation consistent with international obligations, when even the international bodies are not consistent about what is required from states.

[570] Despite the international discourse, the CPMIP Act and IDCCR Act schemes are express legislation in New Zealand. The Court of Appeal's reasoning in *Ruka* applies equally to these Acts. Parliament is sovereign and the judicial function is limited to interpretation of the laws passed by Parliament. The courts cannot refuse to apply a parliamentary process, regardless of whether it is discriminatory or not.

[571] Even when determining whether the process is discriminatory under the appropriate NZBORA analysis, it is difficult to find that the CPMIP Act and IDCCR Act schemes produce a result which materially disadvantages those subject to it, or which cannot be demonstrably justified. These schemes are in place to support those with intellectual disabilities charged with criminal offences, to ensure they are not treated inappropriately. To treat the intellectually disabled as though they were fit to stand trial has been both harmful and unfair in the past. The New Zealand disability

legislation was a response to the harsh and inappropriate treatment of the intellectually disabled in the criminal justice system.

Conclusion

[572] On the review ground of discrimination, I find:

(a) The CPMIP and IDCCR Acts are express legislation in New Zealand, enacted to fill a legislative gap, to provide compulsory care orders for the intellectually disabled, who have been charged with criminal offences. This Court cannot decline to apply those Acts or deem any provision of those Acts ineffective.[365]

(b) The IDCCR Act provides a protective scheme, not a punitive one, for intellectually disabled care recipients, who are diverted from the criminal justice system. The limits prescribed under those two Acts are both reasonably and demonstrably justified under s 5 of the NZBORA.

(c) J has not been materially disadvantaged by the process under the CPMIP Act of being found unfit to stand trial or being made a care recipient and treated under the IDCCR Act.

(d) I find that the CPMIP and IDCCR Acts have not limited J's rights unjustifiably and J's treatment under those Acts has been undertaken lawfully.

[573] I decline the declaratory relief as sought.

Errors of law

[574] In J's amended statement of claim, J seeks relief for his "arbitrary detention" under the review ground of errors of law because J was not detained by RIDCA and/or RIDSAS, as ordered by the District Court. This issue was addressed by Collins J in his judgment dated 11 April 2017, where his Honour held that the original District

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[365] *S*, above n 10, at [446]; and New Zealand Bill of Rights Act 1990, s 4.

Court order of 8 February 2006 was technically incorrect, because it referred to RICDA and/or RIDSAS rather than the Care Coordinator and Care Manager.[366] He found, however, this error was insufficient to invalidate the order.[367]

[575] Similarly, J alleges the District Court erred in law by issuing the original order dated 8 February 2006 detaining J and by issuing the replacement order on 10 January 2017. Collins J has already found the original and amended orders issued under the CPMIP Act were lawful.[368] J pleads under this ground of review that the replacement warrants issued by the District Court were unlawful.

Conclusion

[576] This ground has already been determined by Collins J. This claim is *res judicata* and is hereby dismissed.[369]

Overlapping causes of action

[577] The following causes of action overlap or align with the arguments raised in the CPMIP appeal by J. I deal with each of those causes of action, which Dr Ellis submits remain live in the amended judicial review proceedings.

Cause of action nine – breach of s 9 NZBORA

[578] The basis of this ground of review is that the totality of the treatment or punishment given to J was a breach of s 9 of NZBORA, in that it was disproportionately severe treatment, or if not, a breach of s 23(5). A declaration is sought to this effect.

[579] Section 9 of NZBORA guarantees everyone the right not to be subjected to torture or to cruel, degrading, or disproportionately severe treatment or punishment. The Supreme Court in *Taunoa* describes s 9 of NZBORA as "reserved for truly

366 *J*, above n 3.
367 At [65]–[68].
368 At [49]–[72] and [117].
369 *Contact Energy Ltd v Attorney-General* [2009] NZCA 351 at [71].

egregious cases",[370] involving official conduct "which is to be utterly condemned as outrageous and unacceptable in any circumstances".[371]

[580] On Tipping J's analysis in *Taunoa*, conduct breaching s 9 will usually involve an intention to harm or act with consciously reckless indifference to the causing of harm, as well as significant physical or mental suffering.[372]

[581] Of the various limbs of s 9 which were described by the Supreme Court in *Taunoa*, the most relevant is disproportionately severe treatment. The Supreme Court describes this as being conduct so severe it shocks the national conscience, or so disproportionate it causes shock and revulsion. It is the standard well beyond even manifestly excessive treatment.[373]

[582] J's claim comprises two pleaded facts:

(a) the fact of J's detention under the 2006 District Court order; and

(b) the alleged detention in a secure rather than a supervised facility.

[583] J became a care recipient under the IDCCR Act, not as a punishment, but because he was charged with a criminal offence and was found unfit to stand trial under the CPMIP Act. Collins J addressed this issue in his judgment dated 11 April 2017, where he described J's gateway to the IDCCR Act as criminal offending.[374] However, the IDCCR Act scheme and process involves a civil not criminal scheme.

[584] On the evidence before me, J's claim has no basis. J's detention under the 2006 court order was appropriate, lawful and no miscarriage of justice occurred, as I have earlier found.[375] J's detention in a secure facility is not degrading or disproportionately severe treatment because his risk requires this level of care at present, as earlier discussed.[376]

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370 *Taunoa v Attorney-General* [2007] NZSC 70, [2008] 1 NZLR 429 at [297].
371 At [170] (per Blanchard J) and [339]–[340] (per McGrath J).
372 At [295].
373 At [172] (per Blanchard J) and [289] (per Tipping J).
374 *J*, above n 3, at [7]–[9].
375 At [153] of this judgment.
376 At [423]–[429] of this judgment.

Treatment is not disproportionately severe

[585] J seeks a declaration to the effect that the totality of the treatment he has received, breaches s 9 of NZBORA, because it is disproportionately severe treatment, or, a breach of s 23(5). It is submitted that it would shock the nation's conscience for a person to be detained for 12 years in J's current circumstances. This claim and submission again equates the period of detention to the original offending.

[586] As I have already found, J's index offending does not provide an accurate guide to the level of risk posed by J.[377] I have referred to the Court of Appeal's guidance and the relevance of the proportionality of the period of detention to the original offending. I have also found that Judge Goodwin in the Family Court, correctly applying the guidelines of *RIDCA*,[378] has addressed whether J's detention is "disproportionate" and found J poses a high risk to others, which far outweighs his interest in liberty.[379]

[587] After balancing the community's interest in protecting the safety of J and others against J's interest in liberty, Judge Goodwin concluded:[380]

> … this has not been a finely balanced matter. This is a case where [J's] original minor nature of offending did not provide an accurate guide to the level or risk that he poses, as set out in the reports and oral evidence of the specialist assessors.

[588] In this Court's inquiry under s 102 of the IDCCR Act, I also found that J's risk requires his continued care as a care recipient.[381]

Conclusion

[589] J has not received disproportionately severe treatment as a care recipient under the IDCCR Act or been treated in a way that deliberately inflicts suffering or constitutes any cruel or degrading treatment. There has been no breach of s 9 of NZBORA.

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377 At [408]–[412] of this judgment.
378 *RIDCA*, above n 64.
379 See discussion on *RIDCA* and disproportionality.
380 *Goodwin decision*, above n 95, at [108].
381 At [423]–[429] of this judgment.

Cause of action 11 – Breach of s 23(5) NZBORA

[590] In the alternative, J alleges that his treatment, even if it falls short of s 9 NZBORA, nonetheless breaches s 23(5) and he seeks a declaration against the Attorney-General to that effect.

[591] Section 23(5) provides that "Everyone deprived of liberty shall be treated with humanity and with respect for the inherent dignity of the person."

[592] In *Taunoa*, the Supreme Court described the conduct covered by s 23(5) as conduct that:[382]

> … lacks humanity, but falls short of being cruel; which demeans the person, but not to an extent which is degrading; or which is clearly excessive in the circumstances, but not grossly so.

[593] As the Court cautioned in *Toia v Prison Manager*, when deciding whether s 23(5) has been breached, the Court must consider the duration and severity of the conduct, vulnerability of the detainee, whether the detainee contributed to the conduct and the impact of the conduct on the detainee.[383] In this case, the challenge under s 23(5) relates to the conditions of detention, not the fact of being detained.

[594] Focusing then on the treatment of J throughout his detention, I refer again to the IDCCR Act and its provisions, which require the Care Coordinator to direct where J resides and ensure J received care and rehabilitation in accordance with his care and rehabilitation plan.[384] Again, as I have already canvassed, the care and rehabilitation plan is tailored to the individual care recipient.[385]

[595] As raised in other parts of this decision, J's plans have been reviewed by the Family Court every six months.[386] At the February 2017 review, Dr Webb, giving evidence at that hearing, identified shortcomings in J's care, in that his plans were not tailored to meet his autism. As was appropriate, the care plans were varied to

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382 *Taunoa*, above n 370, at [177] per Blanchard J.
383 *Toia v Prison Manager* [2015] NZCA 624 at [30]–[32] and [36].
384 Intellectual Disability (Compulsory Care and Rehabilitation) Act, ss 47 and 63–64.
385 At [488]–[491] of this judgment.
386 See Appendix 1 of this judgment.

accommodate these concerns and the Judge specifically addressed them in his judgment, as already described.

[596] Similarly, the change in J's status from secure to supervised care in 2011 was to facilitate contact with his mother outside the residential care setting. The Care Coordinator intended that J would remain living where he was and that appropriate staff for his level of risk would continue to be provided to him, but the change in status was sought to assist J in visiting his mother at home. As it transpires, such a change was not necessary to facilitate these visits.

[597] I do not consider there is any evidence that J was treated without dignity or with a lack of humanity. It is correct that concerns were raised about J being isolated, because of his risk and his behaviours but the legislative procedures in place for review of J's continued detention and rehabilitation plans ensured that J was treated more appropriately and specifically for his autism as well as his risks.

Conclusion

[598] I am unable to uphold that there has been a breach of s 23(5) NZBORA. Relief is also declined.

Cause of action 14 and 13 – Stay of proceedings and compensation

[599] As the findings for each of the proceedings reinforce, J's detention was lawful, not arbitrary, and was authorised by judicial decisions under the CPMIP and IDCCR Acts. For the reasons already canvassed under each of these proceedings, J's orders were made after a careful assessment of J's intellectual disability, J's ongoing risk and the care and rehabilitation plans which were reviewed by the Court.

[600] In light of my findings, relief by way of damages (compensatory or exemplary), declaratory relief and a stay of proceedings is declined.

Destruction of the criminal court file

[601] J challenges the District Court's destruction of the District Court criminal file, as a result of his appeal out of time, of the findings in the District Court in 2005 and 2006.

[602] The District Court file appears to have been destroyed in 2016. J challenges the District Court's destruction of the file in this judicial review, alleging that such actions are high handed, contumacious, an abuse of power and are deserving of punishment by means of exemplary damages or compensation.

[603] Section 184 of the Criminal Procedure Act 2011 provides:

> **184 Permanent court record**
>
> (1) Courts conducting criminal proceedings must continue to maintain a permanent court record of the formal steps in those proceedings.
>
> (2) Courts must maintain the permanent court record in accordance with rules of court.
>
> (3) The permanent court record is, subject to the power of the court to amend it, conclusive evidence of the matters recorded in it.

[604] The Crown submits that the Court file was destroyed lawfully, as the Court has maintained J's Court record in accordance with law. The Crown observes that the District Court was required to maintain a Criminal Record of J's charges under s 71 of the Summary Proceedings Act 1957. That record was maintained in the form required by Form 22 of the Summary Proceedings Regulations 1958. This was provided by way of exhibits to Philip Clarke's affidavit sworn 19 June 2017.

[605] The Crown says further, that Form 22 required the Criminal Record to show the District Court, the person charged, the Court number, the hearing date, the prosecutor, the full name and address of the defendant, the plea, the decision and the offence. The Crown says the Summary Proceedings Regulations did not require the District Court to preserve a person's full criminal file.

[606] Section 184 of the Criminal Procedure Act replaced s 71 of the Summary Proceedings Act.[387] Section 184 came into effect on 1 July 2013 and requires the Court to maintain a permanent Court record of the formal steps in criminal proceedings.[388] I accept the Crown's submission that the Criminal Procedure Act, like the previous Summary Proceedings Act, does not require the Court to maintain a person's full criminal file, but the permanent Court record must show all formal steps of a proceeding.[389]

[607] The Crown submits and I accept that the District Court, like all public offices, can dispose of its records with the authority of the chief archivist, as provided under s 18(1) of the Public Records Act 2005. The Crown advises that the District Court's practice is to maintain a full file of a criminal proceeding for 10 years after closure of the file and then destroy it. As Mr Clarke deposes, the chief archivist has authorised the District Court to follow this practice.

Conclusion

[608] I am unable to uphold J's cause of action in respect of the destruction of the Court file, as its destruction was lawful. Nor can I uphold the claim that the actions of the District Court were high-handed, contumacious or an abuse of power. The claim for exemplary damages and/or compensation is dismissed.

Conclusion on judicial review

[609] None of the grounds of review pleaded by J are made out. J's judicial review claim is unsuccessful.

[610] For the sake of completeness, to the extent that I did not consider any of counsels' other submissions, I did not consider they were relevant to the ultimate outcome.

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387 Summary of Proceedings Amendment Act (No 2) 2011, s 7(2).
388 Criminal Procedure Act Commencement Order 2013, cl 2.
389 Criminal Procedure Rules 2012, r 7.2.

SUMMARY OF CONCLUSIONS

Part 1 – The CPMIP Appeal

[611] There has been no miscarriage of justice in J's case and I am satisfied that the findings of his involvement in the offence, his unfitness to stand trial, his mental impairment and the ultimate disposition in an IDCCR Act secure facility were safe and are valid findings.

[612] It is not in the interests of justice to reopen these summary criminal proceedings against J 12 years later or to grant J leave to appeal out of time. J is not prejudiced by his leave to appeal being declined, as he may challenge his continuing care orders through opposing extension applications and by appealing adverse Family Court findings, which he has done in this hearing, together with an application for an inquiry under s 102 of the IDCCR Act.

[613] Even if leave were to be granted, which I do not grant, J's appeal grounds lack merit and his appeal would be dismissed.

[614] Leave to appeal out of time is declined.

Part 2 – Family Court Appeal

[615] The Judge did not err in interpreting and applying the law or in assessing the evidence of the specialist assessors. The Judge carefully considered the evidence before him, as well as J's particular circumstances, and correctly assessed that J's compulsory care order should be extended and varied. The Judge was alive to the issues with J's ongoing care, checked with the liaison District Inspector and took those matters into account in his assessment.

[616] The Family Court appeal is dismissed.

Part 3 – High Court inquiry under section 102 IDCCR Act

[617] I am satisfied that J is not detained illegally as a care recipient, as he does have an intellectual disability. I am further satisfied that J needs to be cared for as a care

recipient, under a compulsory care order at a secure level of care, given J's risk, which is considered to be within the high, to very high range, and constitutes a significant and ongoing risk to the public.

Part 4 – Judicial review proceedings

[618] The judicial review is unsuccessful as none of the grounds of review are made out.

Conclusion on arbitrary detention

[619] J's detention, although prolonged, is not arbitrary:

(a) J's detention is lawful under the CPMIP Act and the IDCCR Act. J's detention is based on his risk to himself and others, as well as his need for treatment and rehabilitation because of his intellectual disability.

(b) J's risk has been measured and assessed by a number of specialist health practitioners, who all affirm the need for J to remain in secure compulsory care, because of the risk to himself and others.

(c) The conditions in which J was held, prior to the variation on his case order in February 2017 did not render J's detention unlawful.

(d) J's detention is not disproportionate and is justified for purposes which align with the principles discussed in the international and New Zealand cases.[390] This review ground is dismissed.

[620] In addition, the three safeguards built into the New Zealand IDCCR legislation, mitigate against the risk of arbitrary detention. They are:

(a) legislative requirements for six monthly reviews of compulsory care orders;

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[390] *Neilsen*, above n 251; *Zaoui*, above n 252; *Miller*, above n 253; *Rameka*, above n 261; and *Fardon*, above n 262.

(b) care orders are time limited and individually focussed; and

(c) District Inspector monitoring and oversight.

Conclusion on discrimination

[621] On the review ground of discrimination, I find:

(a) The CPMIP and IDCCR Acts are express legislation in New Zealand, enacted to fill a legislative gap, to provide compulsory care orders for the intellectually disabled, who have been charged with criminal offences. This Court cannot decline to apply those Acts or deem any provision of those Acts ineffective.[391]

(b) The IDCCR Act provides a protective scheme, not a punitive one, for intellectually disabled care recipients, who are diverted from the criminal justice system. The limits prescribed under those two Acts are both reasonably and demonstrably justified under s 5 of the NZBORA.

(c) J has not been materially disadvantaged by the process under the CPMIP Act of being found unfit to stand trial or being made a care recipient and treated under the IDCCR Act.

(d) I find that the CPMIP and IDCCR Acts have not limited J's rights unjustifiably and J's treatment under those Acts has been undertaken lawfully.

(e) I decline the declaratory relief as sought.

Conclusion on errors of law

[622] This ground has already been determined by Collins J. This claim is *res judicata* and is hereby dismissed.

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391 *S*, above n 10, at [446]; and New Zealand Bill of Rights Act 1990 s 4.

Conclusion on overlapping causes of action

[623] In relation to the causes of action which overlap or align with the arguments J raised in the CPMIP appeal, I find:

(a) There has been no breach of s 9 of NZBORA as J has not received disproportionately severe treatment or been treated in a way that deliberately inflicts suffering or constitutes any cruel or degrading treatment.

(b) There has been no breach of s 23(5) of NZBORA and relief is also declined.

(c) In light of my findings, relief by way of damages (compensatory or exemplary), declaratory relief and a stay of proceedings is declined.

(d) I am unable to uphold J's cause of action in respect of the destruction of the Court file, as its destruction was lawful. Nor can I uphold the claim that the actions of the District Court were high-handed and contumacious and an abuse of power. The claim for exemplary damages and/or compensation is dismissed.

Cull J

Appendix 1 - Chronology

Date	Step/Order	Duration
8 Feb 2006	CPMIP order / Oral judgement of Judge Kerr (s 25(1)(b) disposition)	2 years
8 Feb 2008	J moves to TRT residence in Chapel Downs, Manukau	
18 Jul 2006	Report on appropriateness of compulsory care order and care and rehabilitation plan – s 72 IDCCR Act	
27 Nov 2006	Review by Family Court of compulsory care order and care and rehabilitation plan	
1 Aug 2007	J moves to Pohutukawa Unit, Mason Clinic	
4 Feb 2008	Specialist assessor's review and certificate	
4 Feb 2008	Application to extend compulsory care order and defer expiry – ss 85 and 87 IDCCR Act	
4 Feb 2008	Deferral of expiry	Until application considered
30 Apr 2008	Extension	Six months
28 Jun 2008	Specialist assessor's review and certificate	
11 Jul 2008	Report on appropriateness of compulsory care order and care and rehabilitation plan – s 72 IDCCR Act	
20 Oct 2008	Specialist assessor's review and certificate	
29 Oct 2008	Report on appropriateness of compulsory care order and care and rehabilitation plan – s 72 IDCCR Act	
29 Oct 2008	Application to extend compulsory care order and defer expiry – ss 85 and 87 IDCCR Act	
29 Oct 2008	Deferral	Until further order
28 Jan 2009	Extension	6 months
24 Mar 2009	Specialist assessor's review and certificate	
30 Mar 2009	Report on appropriateness of compulsory care order and care and rehabilitation plan – s 72 IDCCR Act	
10 Jul 2009	Specialist assessor's review and certificate	
16 Jul 2009	Report on appropriateness of compulsory care order and care and rehabilitation plan – s 72 IDCCR Act	
16 Jul 2009	Application to extend compulsory care order – s 85 IDCCR Act	

Date	Step/Order	Duration
27 Jul 2009	Extension	12 months
29 Jan 2010	Specialist assessor's review and certificate	
2 Feb 2010	Report on appropriateness of compulsory care order and care and rehabilitation plan – s 72 IDCCR Act	
8 Jul 2010	Specialist assessor's review and certificate	
19 Jul 2010	Report on appropriateness of compulsory care order and care and rehabilitation plan – s 72 IDCCR Act	
19 Jul 2010	Application to extend compulsory care order and defer expiry – ss 85 and 87 IDCCR Act	
19 Jul 2010	Deferral	3 months
6 Oct 2010	Extension	2 years
4 April 2011	Specialist assessor's review and certificate	
6 April 2011	Report on appropriateness of compulsory care order and care and rehabilitation plan – s 72 IDCCR Act	
17 May 2011	J moves to TRT Motuhake Whare, Mangere (his current residence)	
20 July 2011	Family Court review of appropriateness of compulsory care order and care and rehabilitation plan	
30 Sep 2011	Specialist assessor's review and certificate	
6 Oct 2011	Report on appropriateness of compulsory care order and care and rehabilitation plan – s 72 IDCCR Act	
6 Oct 2011	Application to vary compulsory order from secure to supervised care – s 86 IDCCR Act	
5 Dec 2011	Compulsory care order varied from secure to supervised care	
28 Sep 2012	Specialist assessor's review and certificate	
2 Oct 2012	Report on appropriateness of compulsory care order and care and rehabilitation plan – s 72 IDCCR Act	
2 Oct 2012	Application to extend compulsory care order – ss 85 IDCCR Act	
2 Oct 2012	Application to defer expiry of compulsory care order – s 87 IDCCR Act	
3 Oct 2012	Deferral	3 months
27 Nov 2012	Deferral	
17 Dec 2012	Extension	2 years
7 Jun 2013	Specialist assessor's review and certificate	

Date	Step/Order	Duration
17 Jun 2013	Report on appropriateness of compulsory care order and care and rehabilitation plan – s 72 IDCCR Act	
19 Sep 2013	Family Court Review of compulsory care order and care and rehabilitation plan	
14 Dec 2014	Specialist assessor's review and certificate	
15 Dec 2014	Report on appropriateness of compulsory care order and care and rehabilitation plan – s 72 IDCCR Act	
15 Dec 2014	Application to extend compulsory care order	
15 Dec 2014	Application to defer expiry of compulsory care order – s 87 IDCCR Act	
17 Dec 2014	Deferral	4 months
13 Apr 2015	Extension	18 months
12 Oct 2015	Specialist assessor's review and certificate	
12 Oct 2015	Report on appropriateness of compulsory care order and care and rehabilitation plan – s 72 IDCCR Act	
15 Sep 2016	Specialist assessor's review and certificate	
24 Sep 2016	Specialist assessor's review and certificate	
29 Sep 2016	Report on appropriateness of compulsory care order and care and rehabilitation plan – s 72 IDCCR Act	
29 Sep 2016	Application to extend compulsory care order and defer expiry – ss 85 and 87 IDCCR Act	
3 Oct 2016	Deferral	
25 Nov 2016	Deferral	
28 Feb 2017	Extension and variation to secure care	18 months